DOCUMENT RESUME

ED 329 521 SP 032 906

AUTHOR	Surbeck, Elaine, Ed.; Kelley, Michael F., Ed.
TITLE	Personalizing Care with Infants, Toddlers and Families.
INSTITUTION	Association for Childhood Education International, Wheaton, MD.
REPORT NO	ISBN-0-87173-122-3
PUB DATE	90
NOTE	84p.
AVAILABLE FROM	Association for Childhood Education International, 11141 Georgia Ave., Suite 200, Wheaton, MD 20902 ($10.00, $7.00 for members of ACEI).
PUB TYPE	Collected Works - General (020)
EDRS PRICE	MF01 Plus Postage. PC Not Available from EDRS.
DESCRIPTORS	Child Advocacy; *Child Caregivers; *Child Health; Childhood Attitudes; *Childhood Needs; *Day Care; *Infant Behavior; Infants; *Parent Child Relationship; Preschool Education; Public Policy; Toddlers

ABSTRACT

This publication deals with the present crisis in infant/toddler care. It presents information on infant/toddler development and optimal caregiving paractices, citing recent research on appropriate practices and the impact of poor versus quality care. The book is divided into two sections. In the first section, "Development and Program Implications for Infants, Toddlers and Families," four chapters cover: (1) "The Baby: Birth to 12 Months" (Alice Sterling Honig); (2) "The Second Year: 12 to 24 Months" (Kathryn Castle); (3) "Toddlers: 24 to 36 Months" (Nancy Balaban); and (4) "Quality Integrated Programs for Infants and Toddlers with Special Needs" (David Sexton). The chapters in the second section, "Issues and Dilemmas Confronting Infants, Toddlers and Families," deal with: (5) "Health Issues in a Changing Society" (Veronica D. Feeg); (6) "Infant Day Care" (Michael F. Kelley and Elaine Surbeck); and (7) "Policy Issues Affecting Infants, Toddlers and Their Families" (Eleanor Stokes Szanton). A postscript by Elaine Surbeck concludes the volume. (JD)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED329521

Personalizing Care With Infants, Toddlers and Families

"PERMISSION TO REPRODUCE THIS MATERIAL IN MICROFICHE ONLY HAS BEEN GRANTED BY

L. P. Martin

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☐ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

Elaine Surbeck and Michael F. Kelley, Editors

SP 032 906

BEST COPY AVAILABLE

Sylvia Sunderlin, Consulting Editor
Lucy Prete Martin, Director of Publications
Joan Feldman Saidel, Assistant to Director of Publications
Mary Catherine DeVito, Production Editor

Copyright © 1990, Association for Childhood Education International
11141 Georgia Avenue, Suite 200, Wheaton, MD 20902

Library of Congress Cataloging-in-Publication Data
Personalizing care with infants, toddlers and families / Elaine Surbeck and Michael F. Kelley, editors.
p. cm.
Includes bibliographical references.
ISBN 0-87173-122-3
1. Child development. 2. Infants—Care—United States. 3. Toddlers—Care—United States. 4. Day care centers—United States. I. Surbeck, Elaine. II. Kelley, Michael F.
III. Association for Childhood Education International.
HQ767.9.P47 1990
305.23'1—dc20 90-24570
CIP

Cover photograph by Daniel S. Kelley

Personalizing Care With

Infants, Toddlers and Families

Elaine Surbeck and Michael F. Kelley, Editors

ASSOCIATION FOR
CHILDHOOD EDUCATION INTERNATIONAL
11141 Georgia Avenue, Suite 200, Wheaton, MD 20902
301-942-2443 • 1-800-423-3563

Contents

4 **About the Authors**

6 **Introduction**
Sue C. Wortham

SECTION I
DEVELOPMENT AND PROGRAM IMPLICATIONS FOR INFANTS, TODDLERS AND FAMILIES

10 **Chapter 1**
The Baby: Birth to 12 Months
Alice Sterling Honig

23 **Chapter 2**
The Second Year: 12 to 24 Months
Kathryn Castle

33 **Chapter 3**
Toddlers: 24 to 36 Months
Nancy Balaban

41 **Chapter 4**
Quality Integrated Programs for Infants and Toddlers with Special Needs
David Sexton

SECTION II
ISSUES AND DILEMMAS CONFRONTING INFANTS, TODDLERS AND FAMILIES

52 **Chapter 5**
Health Issues in a Changing Society
Veronica D. Feeg

62 **Chapter 6**
Infant Day Care
Michael F. Kelley and Elaine Surbeck

71 **Chapter 7**
Policy Issues Affecting Infants, Toddlers and Their Families
Eleanor Stokes Szanton

78 **Postscript**
Elaine Surbeck

Photograph © 1990 Hildegard Adler

About the Authors

Each of the contributors to this book has been intimately involved in the lives of infants, toddlers and families. The involvement ranges from crafting and sharing quality programming with young children and their families to educating others to carry on such a worthy undertaking. In addition, most have actively pursued research agendas designed to examine the types and kinds of experience young children and their families currently receive or fail to obtain. Much of their work and effort will be reflected in the chapters of *Personalizing Care with Infants, Toddlers and Families.*

Sue C. Wortham is Associate Professor of Early Childhood and Elementary Education at the University of Texas at San Antonio. Her recent interest in infants and toddlers has been in the design of developmentally appropriate play environments for children between the ages of birth and 3 years. She has authored numerous publications and articles related to early childhood education and served as Chairperson of the ACEI Publications Committee from 1988-1990.

Alice Sterling Honig, Professor of Child Development in the College for Human Development at Syracuse University, New York, is a licensed psychologist working with at-risk infants and children and parents. She was for many years Program Director for the Syracuse Children's Center and Family Development Research Project, which studied longitudinally the outcomes of an omnibus enrichment program for families, infants and preschoolers. Honig has published extensively within a variety of domains related to infants, toddlers and families. Her books include *Infant Caregiving: A Design for Training* (with J.R. Lally); *Parent Involvement in Early Childhood Education; Playtime Learning Games for Young Children* and *Risk Factors in Infancy* (Editor).

Kathryn Castle is Professor in the Department of Curriculum and Instruction at Oklahoma State University, Stillwater. She holds a doctorate in Early Childhood Education/Child Development and is Coordinator of Graduate Studies in Elementary Education. Moreover, she works in the Early Childhood, Elementary, and Curriculum and Supervision programs. She has been a teacher of all ages from toddlers through adults. Her book *The Infant and Toddler Handbook* was written for parents and caregivers.

Nancy Balaban is Director of the Infant and Parent Development Program at Bank Street College Graduate School of Education in New York. She has worked directly with young children and their families for the past 20 years and has been involved in educating teachers of young children for 18 years. She has written a number of articles related to the toddler years and is the author of two books for parents entitled *Starting School: From Separation to Independence* and *Learning To Say Goodbye.*

David Sexton holds a doctorate in Human Ecology with a minor in Special Education and is currently Associate Professor and Chairperson of the Department of Special Education and Habilitative Services at the University of New Orleans. In addition, he serves as the Personnel Preparation Representative on the Louisiana Interagency Coordinating Council for Public Law 99-457. Currently co-authoring a text on early childhood special education, he has published numerous articles

covering a wide variety of issues related to young children with handicaps and their families.

Veronica D. Feeg, R.N., is Associate Professor in the School of Nursing at George Mason University in Fairfax, Virginia. She is the editor of *Pediatric Nursing*, a journal for pediatric nurses in clinical practice, education, administration and research. Her doctoral degree is in Human Development and Family Studies with an emphasis on handicapped children and their families. Her research interests include temperament and child development related to health concerns. She is currently co-editing a resource book for pediatric faculty and clinicians entitled *Core Curriculum for Pediatric Nursing*.

Elaine Surbeck, Assistant Professor of Early Childhood Education, College of Education, Arizona State University, and co-editor of this special publication, received both master and doctoral degrees in Early Childhood Education from the University of Georgia. Formerly a teacher in an infant/parent program, Coordinator of the Child Development Laboratory and Assistant Professor of Child Development at ASU, she has taught courses and conducted research in infancy, child development and preschool through primary education. She and Michael Kelley have co-authored several recent book chapters related to assessment issues in early childhood education.

Michael F. Kelley, co-editor of this book with Elaine Surbeck, is Assistant Professor of Early Childhood Education, Education and Human Services, Arizona State University West, and educational consultant specializing in early childhood programs. He holds B.S. and M.S. degrees in Child Development and Family Studies from ASU and a doctorate in Early Childhood Education from the University of Georgia. Formerly a child care provider and preschool teacher, he is currently teaching university courses related to infants and toddlers, among others, and conducts early childhood education program evaluations for local and state entities.

Eleanor Stokes Szanton has been Executive Director of the National Center for Clinical Infant Programs in Washington, D.C., almost since its foundation. She received a Ph.D. in Human Development from the University of Maryland and an M.Ed. from the Harvard Graduate School of Education. She is Vice-President of the Board of the Family Resource Coalition, Chicago, Illinois, and serves on the Board of Education for Parenting, Philadelphia, Pennsylvania. She has authored a number of publications relating healthy infant development and public policy.

It is our intent as editors and authors to argue for a conception of personalized care that is sensitive to the unique needs of infants, toddlers, their families and care providers as they participate together in a multitude of daily arrangements. Thus, the phrase *personalizing care with* is used in the title, rather than *personalizing care for*, to suggest a more interactive and interpersonal process in personalizing care. We believe that the contents of this book reflect this perspective and hope that readers will consider the importance of this issue as they proceed through the various chapters.

—Elaine Surbeck and Michael F. Kelley, Editors

Acknowledgment: As editors of this book, we would like to thank the contributing authors for the quality of their work. In addition, acknowledgment and appreciation are extended to the following individuals: Renee Adams, Nita Barbour, John R. Cryan and E. Anne Eddowes of the ACEI Publications Committee for their helpful comments on an earlier version of this manuscript; Herbert Zimiles for his critical comments as an outside reviewer; Barbara Mezzio for her insights as a parent and care provider; Consulting Editor Sylvia Sunderlin; and ACEI Director of Publications Lucy Prete Martin and her staff who worked with us to see this book to completion.

Introduction

Sue C. Wortham
The University of Texas at San Antonio

Elizabeth, age 6, and her brother Miles, age 3, both entered day care before they were 2 months old. Elizabeth was placed in a family home-care setting for 8 months, then moved to a child enrichment center housed in a local church until she entered public school. Miles was later placed in the child enrichment center with his sister when his mother returned to work two months after his birth. When Elizabeth entered school, Miles was moved to a smaller, home-like center that provided extended care for Elizabeth and transportation to and from her school.

The two children reacted differently to the child care experience. Elizabeth was very sensitive to changes in routines and caregivers. She had frequent serious illnesses and developed asthma when she was moved from the family home to a center-based setting. She often cried when left with the caregiver and was fearful when substitute caregivers replaced her "teacher."

Miles was more resilient. As an infant, he adapted to all caregivers and his outgoing, friendly personality attracted positive attention from staff at the center. When he was moved from the infant area to the toddler room, his mother's concern about the change in caregivers and environment was quickly alleviated when she realized how happy Miles was with the rich selection of toys available for the toddlers.

The parents of these children struggled with many of the problems, issues and concerns involved in having children in infant, toddler and preschool care, including feelings of anxiety and guilt over leaving their babies in child care. The high turnover in caregivers, caregiver absences and the difficulty of finding alternative care when their babies were ill only served to heighten these feelings.

Elizabeth and Miles are a part of the statistics on the rising number of infants and toddlers entering day care each year. Not only has the quality of care they received as babies affected their development and well-being, but the daily routine of preparing them to enter care has had an impact on their family unit. Both children and parents have been influenced by the relationships they have developed with various center staff members.

This publication, *Personalizing Care with Infants, Toddlers and Families*, is a response to the present crisis in infant/toddler care. It extends the advocacy role that the Association for Childhood Education International (ACEI) has played for almost a century in supporting children and families. The editors have selected national leaders in the field of infant and toddler care to present current information on infant/toddler development and optimal caregiving practices with these very youngest children in our society. These authors address the issues facing parents and staff members in caregiving settings as they seek to personalize care with infants and toddlers, citing the latest research on appropriate practices and the impact of poor versus quality care. The authors give the reader perspective on the challenges ahead as numbers of infants and toddlers in day care continue to rise.

Although this volume was written to address the urgency of personalizing quality care with infants, toddlers and their families, perhaps the most significant

© 1990 Michael Tony—TOPIX

emphasis is the focus on the needs of the individual child. Just as Elizabeth and Miles were different in their adjustment to child care as infants and varied individually in how they affected their caregivers and benefited from their experiences, so is every infant entering care unique. The authors stress that infant care ultimately must focus on the individual. Quality care is personalized for the needs of each child.

This book is divided into two sections. The four chapters comprising Section I focus on the interplay between development and quality programming. In the first chapter Alice Honig, a pioneer in the field of infant and toddler development, helps us understand the nature of the infant in the first 12 months of life. She identifies and describes the major accomplishments and milestones we all come to expect from developing, healthy babies, and she clearly relates important caregiver practices that enhance infant development.

In chapter 2 Kathryn Castle shows us that the second year of life is a picture of contrasts between emerging young toddler independence and the need for caregiver nurturance. Her rich descriptions or "vignettes" of toddler action characterize the vitality of the young toddler. Moreover, within each subsection, Castle describes quality caregiver practices and program implications that emerge from an understanding of the developing toddler.

While the second chapter focuses on the young toddler, chapter 3 by Nancy Balaban directs our attention to the older toddler who is 24 to 36 months of age. She also uses rich descriptions of child behavior to bring to life the developmental changes older toddlers undergo. Issues of separation and developmental transitions are addressed within this chapter along with a variety of program implications. Both

chapters 2 and 3 stress the need for quality family support should infant/toddler out-of-home care become a necessity.

Chapter 4 of Section I by David Sexton is informative and timely. We rarely take the opportunity to consider programs for infants and toddlers with special needs within an integrative framework. This chapter provides information about Public Law 99-457 and its implications for infant and toddler programs. Sexton encourages us to consider the program needs of young handicapped infants and toddlers, and he argues for meeting those needs within currently existing child care and education programs. The checklist appended to his chapter may prove helpful to readers interested in assessing the integrative nature of their current environments.

Section II addresses a number of the issues and dilemmas confronting infants, toddlers and families. In chapter 5 Veronica Feeg shares some rather startling and disturbing information about the status of American children's health, demonstrating that families and children today are at greater risk than ever due to a variety of health-related and environmental factors. Fortunately, Feeg has many family-focused suggestions for improving the health status of our very youngest children.

Another issue receiving major attention today is the controversy over child care for young children. In chapter 6 the editors of this book help us to explore that controversy. Out-of-home care for young infants and toddlers is growing considerably. Because of this, Michael F. Kelley and Elaine Surbeck ask the question, "Which type of care provision available will offer the most personalized, dependable and affectionate form of experience possible for the young infant?" They examine the infant day care debate and show how the level of personalization of care interacts with group composition facets to affect the quality of experience received by infants. Finally, they touch on some issues that must be addressed in the coming decade.

The final chapter focuses our attention upon policies that influence what infants, toddlers and their families receive or fail to receive. Eleanor Szanton of the National Center for Clinical Infant Programs reviews the current status of our youngest children and their families and highlights some of the current, pressing policy issues affecting children and families. She argues for an integrative service delivery model for meeting family needs rather than the currently used categorical model—and she provides some well-focused suggestions for meeting family and child needs.

Parents, caregivers and other adults responsible for caring for infants and toddlers will find this volume a valuable resource. Both current and practical, it is a response made by ACEI to meet the critical need for the best information available on how to care for our youngest children. ACEI hopes that each of you will heed the call to action in the Postscript by informing as many individuals as possible about the need to personalize care with infants, toddlers and families.

Section I

Development and Program Implications for Infants, Toddlers and Families

Chapter 1

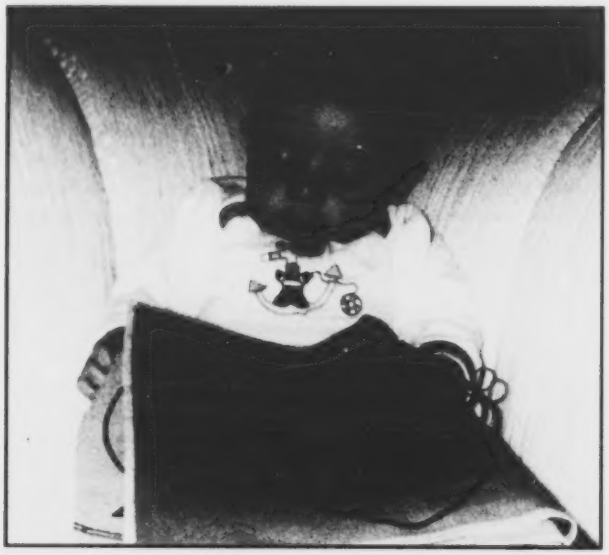
The Baby— Birth to 12 Months

Alice Sterling Honig
Syracuse University

The baby lay curled on his side, his tiny fists clenched. Wispy dark hair covered his body as well as his scalp. A frown crossed his still wrinkled and dark-reddish little face. "Isn't he the most beautiful baby in the world?" Papa asked or rather affirmed admiringly to his fellow office worker, who had come calling to pay respects to the 2-week-old newborn and his parents. At their voices, the neonate stirred, stretched and let out a cranky wail, high-pitched and protesting. The tiny tummy had not been filled for nearly three hours and the hunger that assailed the gut was communicated in increasingly piercing wails that brought Mama hurrying into the nursery. "First I have to change you, love, and then I'll nurse you right away," she reassured the little one. Eyes still shut, the baby felt the comfort of her cheek against his as the mother walked to the diapering table. She had been putting her cheek against his from the first day, reassuring him that hunger would not devour him, that help was on its way in the form of warm milk and a nuzzle against a warm breast. And the baby did quiet down while being diapered! Only 2 weeks old, baby was already learning the beginning of basic trust, the most important emotional experience of the first year of life.

How did the newborn appear in those early weeks? The little wrinkly legs were still bowed, the ankles not straight but turned in, the thighs and buttocks skinny, not yet firmed out into the pink-hued rounded outlines so enchanting in Gerber ads and parent magazines. Stools were pasty, yellow and soft—just normal for a breast-fed baby. The circumcision looked healed already, and the umbilical cord healing was coming along nicely. After a fresh diaper was securely in place, baby was ready for a nuzzle and a feed. With loud sucking noises, and with the expertise gained in these first weeks, he unerringly turned to the nipple, latched on and began the greedy, noisy gulps his parents likened to those of a frantic piglet.

It would take several weeks of being nursed on demand, whenever the internal signals of hunger began their raging course through his body, for the baby to learn that milk and comfort were but minutes away, that he did not have to fall apart instantly when hungry or wet or just waking from sleep. But these were the early weeks. Trust takes time to build, and his parents were building that early lesson in gut-syllogistic reasoning. "If I am needy, someone will come promptly and find out what I need. If I am hungry, someone cares enough to feed me. If I am distressed, then my needs are important, and someone will try to interpret my cries and make things better." After the feed, Papa knew from experience that burping was hard for this baby. Unlike their firstborn, who had burped easily, this one needed to be walked around the room. Even though a mother has excellent prenatal care, with no smoking, alcohol or drugs



John C. Meyer, Jr.

to impair intrauterine growth, normal babies need time to adjust to life outside the womb. Back rubs and pats, firm yet gentle thumps, may be needed to bring up a gas bubble. Otherwise, if baby were put down again, the gas pains would cause a piercing cry. The little legs would double up to the knees. Papa walked the floor, jiggling gently, with baby on his shoulder, massaging the back and giving firm pats. Finally the baby passed gas through the rectum and, soon, also gave a big burp. The parents smiled at each other. The distress of a new tummy and a new nervous system makes life rough in the first months for some babies. Caregivers often feel a real sense of victory when they can figure out how to make life more comfortable for the newborn. Massages help (Leboyer, 1976). Swaddling babies firmly in receiving blankets calms and helps them stay organized rather than disorganized in response to sudden changes in position or loud sounds.

This vignette of a baby not yet a month old helps set the stage for our understanding of babies in the first 12 months of life. Babies are born not entirely helpless. They can cough, sneeze, squint down to protect their eyes against a bright light, stretch, yawn, squirm and root to find the nipple with nourishing breast milk or iron-fortified formula. In a few weeks, the baby can turn head and eyes to find the source of a familiar voice.

Early Reflexes

In the early weeks of infancy baby shows reflex behaviors, many of which will drop out in the next weeks in the course of normal development. Tickle the sole of one foot, and both feet and perhaps even the arms are likely to move—in an "all or none" response. Later, just the tickled foot will flex. Most babies in the early weeks position themselves in either a right tonic neck reflex (TNR) or left TNR. That is, the arm and leg are extended on the side toward which the baby's head is turned and the opposite arm and leg are drawn up and flexed, much as in fencing position. Some babies show

an alternation of right and left TNR. Because of the TNR, mobiles should not be hung over the midline of the body during the early weeks; they may arouse increased irritability and crying, since the neonate is a side-oriented creature in the early weeks of life.

The TNR is useful in helping baby adapt to being held for a feeding. The body turns to the side easily when a cheek is stroked or touched, making nursing easier. Babies should not be given propped bottles. Feeding is a fundamental social activity of humans. Babies from the beginning bring an adaptive TNR and a rooting reflex to the feeding process. The human adult partner from day one needs to help babies enjoy and learn the intimate sociability of feeding while being held.

The Babinski reflex involves a fanning of the great toe if the sole is stroked. In normal babies this disappears after a few weeks. The Moro or startle reflex can be seen as babies throw out their arms and stiffen if a loud sound startles them or they lose bodily support.

A sensory stimulus barrier protects many newborns from a too-noisy environment in the first weeks. If there is sensory overstimulation, the baby "shuts down" and goes to sleep. Before the third month, however, babies have a lowered sensory barrier and may cry more frequently and react with distress to a too-chaotic, noisy surrounding.

Gaining Muscular Control from Head to Toe

Neurological control grows more slowly for some infants, particularly those damaged because of prenatal drug use by the mother. But even for normal babies, there is still chin trembling and head bobbing during the early weeks. The powerful grasp reflex allows babies from the first days of life to curl their fingers around those of adults and be pulled up to sitting from supine position. After a few weeks, head lag is minimal. Now when the baby is pulled to sitting, the head rights itself along with the body. By the end of the first 3 months, head control is usually very good. A baby placed on the tummy will lift the trunk so that the sternum is raised; the head lifts for a look around to see interesting sights in front or to the side. Placing babies on a safe warm floor space allows 3-month-olds to practice these wonderful pushing-up skills and use their oculomotor muscles together in coordinated ways.

Because development is cephalocaudal (i.e., from head to toe), control over the eye muscles and head turning will come before control over the hands. And, in turn, control over the upper trunk will come before control over the lower trunk and leg muscles. The eye muscles, however, are in such good control by 3 months that the baby can follow a red embroidery hoop, not only twirled slowly in a vertical path from tummy upward and back down, but also horizontally across the line of vision. A month later, baby can even follow the red hoop twirled slowly in a circle above as he or she lies on the back.

The Hand System

By 3 months, baby's hands are no longer tight-fisted but open, although often curled. Their next great advance is batting and swiping at mobiles or safe, swinging toys placed over the hands while baby is in a crib or strapped securely on a diapering table. The feet, too, like to thrust and exercise by kicking mobiles placed over them. There is no intentionality to kick purposefully as yet. The baby doesn't "decide" to make the mobile dance in the air. Anticipation of the pleasurable swiping game and intentional purposeful actions to initiate the game will come in near 8 months, the beginning of Piaget's Sensorimotor Stage 4. But by 4 months, the baby (who has begun to learn

through body generosity and attunement of caregivers that life is more predictable than in the early months when the raging needs of belly and guts were all-important) can now keep on kicking a mobile with nursery birds so that the birds dance in the air for over 20 minutes. What a long attention span and such good exercise for baby muscles!

By 5 and 6 months, baby can corral objects. The hands, used as a whole in a raking motion, can swipe at and gather blocks and safe toys in a bunch toward the body. The scissors grasp, which comes next, will permit the baby to begin trying to pick up cubes and safe toys with more use of the first and second fingers as well as support from the other fingers. Not until 10 to 12 months will the fine precision grasp of *pincer prehension* permit the baby to pick up a tender crumb from a bib or a piece of dust from under the living room couch. Fortunately for babies, Dr. Spock reassures us, a teaspoon full of dust a day will not hurt a baby!

The hand system grows apace. By 9 to 10 months the *poking index finger* comes into its own. Baby can imperiously point to objects desired. Babies finally will be able to curl their fists around a peg and try to manipulate a chubby peg into a pegboard. But even after the fine-tuned control of pincer prehension is in place at the end of the first year, babies will still tip a training cup too far or not far enough. Spills will still happen since full wrist control does not come in until well after the first year.

The hands at 4 months meet at the midline of the body. Fingers grasp and pull at one another. Babies at 4 months may wave their hands in and out of their line of vision, as if wondering about and learning the mighty, curious fact that these objects with five curling fingers have a topside and an underside. Often, babies even smack themselves in the face when first beginning such wavings! They need to learn to modulate the force from the shoulder that sends the hands into motion. The eyes bring the hands into the field of vision and hold them there, even as the mouth seemed to have the power to bring the thumb and fist to itself over and over for the comforting sucks that helped a baby before 1 month to gain control over distress, to achieve homeostasis (Greenspan, Nover & Scheuer, 1986). At 5 months, babies love to squeeze, crumple and tear paper. By 6 to 7 months, "shake-shake" becomes a great game for a baby. Put a rattle in a baby's hand and cheerfully start an imitation game of "shake-shake." Babies love to wave and shake and rattle toys that produce sounds. The 9-month-old can vigorously ring a bell with a clapper.

At about 7 to 8 months, a great developmental watershed appears. The baby begins to be able to use two hands together to play that wonderful game of pattycake. With much pleasure the hands are brought over and over to the midline. Chanting and singing by beloved caregivers help the baby to enjoy the pattycake game even more (Honig & Lally, 1981). Also, the baby begins to use hands purposefully to examine toys. This new behavior is an excellent sign of the beginning of intellectually curious explorations that are directed by the baby's growing intelligence. Put a new toy into the baby's hands at 9 months. First the baby may wave it, bang it, poke, turn it over, touch parts of the toy and then mouth it. This change at about 8 to 9 months from mindless mouthing of the earlier months to curious exploration and examination of a toy is a great sign of the beginning of inquiry about the world, the beginning of awareness of action upon objects that will flower later into the period between 12 to 18 months that I call the "What will happen if?" stage, when all toys (including toilet paper rolls to be unwound) are grist for the baby's persistent curiosity. In this Piagetian Stage 5 (sensorimotor period lasting from birth to about 2 years), babies create new experiences and try to find out how things and people work (Piaget, 1952).

Another great coordination that becomes available to the infant by the end of the first 10 to 11 months is the ability to use two objects in combination. Babies may be able to lower a cube into a cup. Of course, because hand-release skills are rudimentary until 11 to 12 months, that hand may come up out of the cup still clutching the cube! Babies can bang two blocks together, cover or uncover a toy with a cloth or bang with a spoon on a table or a toy. From 7 months onward they can hold two cubes, and some babies begin to be able to bang two cubes together to make noises. Playing with one toy at a time (and dropping that one for a new toy) changes at about 9 to 10 months to incipient ability to play by combining toys, a skill that will develop into the ability to hold onto a toy with one hand and do complex operations, such as winding up a Jack-in-the-Box with the other hand, during the next year of life. By 1 year babies can hold one cube in each hand and either grab for a third by opening one fist, or reach down and hold a proffered third cube in the mouth. Babies can also hold one toy in each hand and appreciate each by slow alternate glancing from one toy to the other.

Other Piagetian Sensorimotor Learnings

Imitation games during the first year begin with babies imitating gestures visible and familiar to them. Pattycake is an ideal imitation game for babies, since they have been interlacing fingers of both hands and getting their own hands together for months. Imitation of visible unfamiliar gestures may occur after 12 months. The most difficult imitation of unfamiliar, invisible gestures such as eye winks will be accomplished only at the end of the Piagetian sensorimotor period (Stage 6), usually from 18 months onward.

Object permanence learning is helped into place by the baby's maturing nervous system and the peek-a-boo games that caregivers play. Between 8 and 12 months, the baby begins to realize that out-of-sight is not gone forever. The baby will search around with eyes for objects dropped ostentatiously from the edge of a table. Baby begins to pull off a cup or cloth from a hidden toy. At first, baby may need to have a part of the toy sticking out in order to search under a cloth. Or the baby's hand may need to be "going for" the toy in order to continue successfully on the trajectory in space that leads to retrieving the toy under the cloth. By 1 year baby will victoriously be able to solve the problem of the hidden object under a variety of "screens" without being in the act of reaching at the time the toy is hidden. By Stage 6 of the Piagetian sensorimotor period, baby can remember the order in which you hid a toy under several screens while the toy was already hidden in your fist. But at 8 to 12 months, the victory of searching in one place for a completely hidden toy (hidden while baby watches) is still a new accomplishment.

Spatial understandings are hard for babies. They may grasp for objects well out of their reach. By 8 months they have learned that some objects, such as their bottles, have a front and back; they will turn the bottle around if it is handed in reversed position in order to get at the nipple.

Depth perception is clearly demonstrated by 8 to 9 months. Those babies who can locomote show a clear response to the perceived danger of a "visual cliff." Depth perception seems to have a strong innate component. Babies are placed on a large glass table with a patterned material positioned under the table so that the surface seems solid for half the table length but a sharp drop-off seems to exist for the other half of the table. Babies avoid the "deep" side of the seeming cliff. Although the glass table is firmly supporting them as they move, they won't cross over.

Teething and Feeding

The first teeth, the two center lower teeth, may erupt by the seventh month. Some babies barely get one tooth by the end of the first year, yet others have quite a few teeth and can even handle junior foods. A baby needs to learn to keep the mouth closed and swallow spit that accumulates. During the first 2 years, caregivers are well advised to keep wipers handy for spitups and drool. Teething brings special problems. Babies often have a ferocious need to bite on a teether.

Nutrition for toothless infants must take into account the difficulty a baby has in handling solid foods. The nursed baby has sufficient nutrients in breast milk from a well-nourished mother to wait until about 9 months to begin solids. Fresh orange juice, rice cereal and ripe mashed banana can be sufficient as introductions to solid foods. Babies have trouble learning to manipulate tongue and jaws for mature chewing. They tongue-thrust and food dribbles out of the mouth. Babies need adult patience and acceptance while they struggle to handle strained baby foods.

Some babies allergic to the protein in cow's milk break out in hives unless given special formulas. Introduction of whole cow's milk should wait until the end of the first year. Cow's milk may cause enteric bleeding and has almost no bioavailable iron, which maternal milk has. Bottle-fed infants from birth and breast-fed infants after 8 months need foods fortified with iron. Otherwise, irritability, lowered IQ scores and other behavioral deficits may occur. These are, however, reversible when intramuscular iron is provided and diet is enhanced with iron (Honig & Oski, 1986).

Babies make a mess while eating. They squeeze food between fingers and use feeding times for sensory pleasures and explorations. Sitting in high chairs, they may drop food just to see where it falls and how it splashes. They prefer to feed themselves even though they can't quite manage to get enough food at first and an adult must help.

Feeding times need to be leisurely and pleasurable for babies. The fierce urgency to "do it myself" that characterizes the baby at the apex of the first year and moving into the second year will make baby impatiently slap away a spoon in the hand of a caregiver. A sense of humor helps. This messy, dribbly, food-lathered creature will one day learn to use utensils with dexterity. For now, let baby hold another spoon while being fed. Put safe foods, such as a well-cooked hunk of carrot, a teething biscuit or a peeled chunk of raw apple, into the baby's fist. Prepare cereals that are iron-fortified and thick enough to stick to the bowl or a spoon. Baby, with wobbly wrist control, can still get some cereal onto her or his very own spoon. Yogurt is much appreciated, as are tiny cooked peas, mashed potatoes, noodles and applesauce. Remember that some foods can help bind loose stools. Apples, cooked carrots and rice are useful for firming the stool.

Don't force new foods. Lure babies with small portions to taste new textures and foods when they are hungry. Prehension skills are advanced by finger feeding. A baby picking up a wiggly strand of spaghetti or pieces of cereal from a high chair tray gets practice in dexterity as well as a boost to self-confidence and sense of autonomy (Honig & Lally, 1981).

Settling the Body into Routines and Rhythms

Feeding, sleep and voiding patterns vary widely among babies during the first year. Some babies begin to sleep through the night after a late night nursing as early as a few months. Others may wake several times a night for nursings throughout the first year and longer. Some babies may start to sleep through the night. Then, later, they

John C. Meyer, Jr.

may develop resistance to getting to sleep as they begin to react with anger and fussiness to the loss of adult company and interesting activities.

Some babies can self-comfort by putting a thumb to mouth or calm themselves by finding the caregiver's reassuring face. Some need extra adult support to calm down or get to sleep. Rhythmic back pats or soothing rubs or massages help ease some babies' tensions. *Homeostasis* is the primary goal for the early months (Greenspan et al., 1986). Helping a baby find ways to get back into equilibrium when distressed is an important *mutual regulatory activity* that caregivers must engage in with young infants. Winnicott (1987) has noted that there is no such thing as a baby—only a baby plus caregiver. That wise remark emphasizes the importance of helping the baby find ways to regain inner peacefulness in the early months.

Infants move in and out of a variety of states, such as drowsiness, light sleep, deep sleep, restless thrashing/awake, alert/inactive/awake, and crying. Engaging an infant in learning games is best initiated when the infant is calm and awake.

Young infants void frequently, so diaper changes need to be frequent. Urine, over time, changes to ammonia, causing irritation and diaper rash. Infants with greenish stools or mucous in loose stools may have an infection needing prompt medical attention. Dehydration occurs rapidly for a tiny baby with diarrhea. Bottle-fed babies on solid foods can develop a hard stool, pellets that cause pain in passing and even anal fissures. The diet may need to be changed, but lubrication of the anal area can also ease the passing of a hard stool.

Locomotion and Position Changes

The last quarter of the first year heralds the arrival of early locomotor skills. Going from a lie-down to a sit-up to a cruising-around vertical life is a stunning change. The power to get to persons and things you want is a great and heady joy. Indeed, by 1 year many cruising babies are at a "cusp of joy" in their lives—giddy with powers to locomote, yet too young to know that their omnipotence is illusory. Enjoy babies during this period. Soon, in the second year, the growing mind of the baby will impel awareness of separations, vulnerabilities and frustrations that will cause much crankiness in that "gray" period during year 2 that Mahler calls "rapprochement" (Kaplan, 1978) and that Erikson (1950) calls the struggle between a sturdy sense of autonomy and a lasting sense of doubt or shame about one's self and one's abilities.

Walking, as is the case with dentition and the appearance of the first teeth, is very much genetically determined. Babies will locomote when they are ready, just as they will develop teeth (with more or less teething misery) also when their genetic timetables permit. There is no relation between a baby's early production of teeth or early walking and later intelligence.

Rolling over occurs earlier or later for different babies. It is most unwise to leave a baby alone on a bed or any raised surface after 3 months. Some babies begin to roll onto a side from their backs very early, although learning to roll from and to all positions, side, front or back, will take months of practice. By 6 months, a baby who has already learned to turn over from back to tummy may learn to turn from tummy to back. Freedom on a warm, safe floor provides the best opportunity to practice these gross motor skills.

Some babies show more interest in moving earlier than others. A quality caregiver lures a baby by putting interesting toys just out of reach, a bit to the side or in front to encourage, but does not force baby stretches and exercises, which are the prelude to developing locomotion skills. Most babies can get themselves to a sitting position by 8 months and maintain that position for quite a while without getting fatigued. Forcing early sitting is not good for the back muscles. Propping a baby with pillows or using an infant seat for a while so baby can follow you with eyes as you work in a room is a fine idea, but babies should not be left propped for hours.

Some babies are ready to begin the exercises that will lead to locomotion when they are 6 months old. A baby placed on a firm, warm floor may rear her or his torso off the floor and rock back and forth with tummy high off the floor. These practices are the beginning stages of the ability to pad off, adeptly using opposite hand and foot, or to scoot, using a pole-like motion of one leg. Such skills are sometimes well advanced by 9 months. Other babies, still peacefully stationary at that age, are content to wave and kick and reach and play with grasped toys. Quite chubby babies may have more trouble beginning to turn over and try locomotions.

Crawling, which appears earlier than creeping, involves hitching oneself along with belly to the ground. Creeping requires coordination of opposite limbs with the tummy held high off the ground. Creeping is an efficient and rapid way in which some 9- to 12-month-olds will be getting around, while others will be stationary and still others will be in the early stages of the crawl. Gesell, with his "cinemanalysis" slow-movie-frame technique a half-century ago, filmed about two dozen unique ways in which babies first negotiate movement in space.

Infant walkers are not good for babies. They keep babies "out of trouble" if a floor is cluttered. If left in them for hours, however, babies can develop bowed legs. Worse, babies will not get the feedback experiences they need from picking up, handling and

putting down toys. It is better to clear a safe floor space and let baby be free to get feedback from explorations of space under tables and around obstacles—from chair legs, toys, balls, toy animals, dolls, squeak toys, blocks and other household playthings.

Baby: The Budding Scientist

Causality learning is crucial for young ones. The beginnings of motivation to become a budding scientist are in the infancy years. Cause and effect and the relation of some gestures as means (such as pulling a string) and other gestures as ends or goals (as in chewing on the soft squeak toy that is at the end of that string) are significant scientific learnings. A baby in a walker, excluded from such advantages, cannot get prompt feedback from toys rolled, tasted, pushed, pulled, dropped in and out of containers. Actions on objects are necessary for babies to begin to learn categories and classifications (Piaget, 1952). Early actions focus on the body, waving hands or playing with toes. By 9 months, babies need a variety of safe manipulables to handle; important toys like family pots and pans are supremely interesting to babies.

Prior to the 8th or 9th month, magic reigns in the infant's understanding of causality. Often, if an interesting spectacle is viewed or heard and then ceases, a baby may just wait for the attraction to appear or sound again. Or the baby may vigorously thrust legs or shake as if body motions per se could restart interesting acts. But toward the 9 month-milestone, a big advance in causal understanding occurs. The baby begins to realize that an agent is required for certain spectacles to restart. At this age, a baby may take an adult's hand and place it on the large top that has just stopped spinning and rests silently on the floor. Or baby may bring a toy to the adult and put it in the adult's hands as if to say, "I know now that somebody has to act on this toy in order for it to work and you are my special person who can make this happen." These actions are beginnings of true causality understandings, since the baby begins to realize that wishing alone will not make things happen. People have to turn knobs, wind up toys, push buttons.

The 9-month-old will probably enjoy a game of turning a light switch on and off for quite a while. This game, where the effects of the action are immediately visible in the light flux in the room, is a good game for a baby in your arms to play. Toys can be helpful too. An infant can create an effect by pushing on a toy or pulling open a door to retrieve a colorful ball or toy behind the door. Turning-mechanism toys are still too difficult for the 9-month-old because wrist control is not in place. But simple causality toys should add zest to baby's play, since they require a separation of means-ends relations and they rely on the understanding of intentionality and anticipation, which are coming into place in the last quarter of the first year. Just pushing a toy off the edge of a table so that it tumbles is a good elementary causality game—especially if the toy is a cup with liquid and the additional response besides the spilled puddle is an adult yell of surprise as the cup falls!

Learning Love and Intimacy

Learning to love and trust—to get love from and to count on the generosity and trustworthiness of the caregiver—is the fundamental and crucial emotional lesson of the first year of life (Erikson, 1950). Without such rich and repeated lessons, the infant may grow up with limited emotional resources. Babies whose caregivers are emotionally unavailable (uncomfortable in bodily intimacy, unable to empathize with infant despairs and indifferent to needs) have sharply decreased IQ scores by 2

years of age. By 1 year such babies, *avoidantly attached* (Ainsworth, 1982), may avert meeting the caregiver's eyes, as if they did not miss her or him after a reunion. They may cope with lack of the body loving I call "dominion over the caregiver's body" by not seeking such contact after separation. Babies need to count on adult attunement to their discomforts. A caregiver who interprets distress signals accurately and meets the needs of distress promptly and comfortingly is teaching the baby the somatic certainty of his or her worthiness. Wholeness of emotional being flows from such intimate holdings, ministrations, snuggles and drapes (Honig, 1983).

Some caregivers provide such loving only at the convenience of the adult. Babies who have not experienced responsiveness to their cues and needs cannot cope with the inconsistencies of self-centered caregivers but, in turn, may sometimes actively seek and then reject adult comforting or even become angry with the adult who has been so inconsistent. Such babies have been labeled as *anxiously ambivalent* or resistive in their attachment (Ainsworth, 1982; Bretherton & Waters, 1986). They want comfort after reunion but seem unable to accept it, and they strike out at the caregiver or squirm to get down rather than molding peaceably on her or his body. Other insecure babies show mixtures of disturbance, a dazed quality of launching into early mobility by careening and moving aimlessly about, as if there were not a central figure to return to, as if the central core of trustworthiness, consistency and body availability had not been firmly or lengthily established at leisure. Because these patterns of secure versus avoidant, ambivalent/resistive and dazed/insecure attachment are developed in the attunements or mismatches, empathy and insensitivity of adults during the first year of life, caregivers need to be particularly thoughtful about choices for care and modes of care for babies during these months. With such carefulness, secure attachments of infants (with their parents) in high quality group care for a half day during the first year need not be compromised (Caldwell, Wright, Honig & Tannenbaum, 1970; Honig, 1990).

If there is consistency of care, if special "tuned-in" persons meet the baby's needs contingently and light up with joy and admiration at the baby's growing accomplishments of eye-hand coordination, exploration, discovery, game participation and language learning—then baby will experience joy, which is elusive. It depends on the special one who is available, on whose body baby finds consolation, safety, repose, comfort and nourishment. Babies need dominion over a caregiver's body (Honig, 1981, 1982, 1989). If attunement has been subtle and generous, if the adult has managed to endure the sleeplessness, the frustration of interpreting the early cries, the drudgery of endless diaper changes, and if the adult has himself or herself guarded that precious quality of confidence and joy remembered from ministrations of a loving adult somewhere in the caregiver's past—then the baby will learn love.

What are the stages of love? The baby by 5 to 6 months should exhibit what Mahler calls the "hatched" look (Kaplan, 1978). No longer is the baby turned mostly inward to signals from the gut or diaper area. Now the baby is bright-eyed and alert to the wonders of the outer world. From a perch of security in the beloved adult's arms, the well-hatched baby turns with genuine and even eager interest to the stranger and can approach new toys with zest and purposeful explorations. Laughter and smiles at absurd peek-a-boo games, funny faces and funny noises (try *physicist* or *foo foo*) can send an 8-month-old into grins and giggles (Honig, 1985). Responsiveness to infant cues and empathic attunement to the emotional states of the baby need to occur in such a manner that the distressed baby's needs are met without the caregiver's falling

apart at baby anguish. Nor should an adult ignore the baby's cries and needs to keep from identifying too much with the baby's anguish, as this anguish resonates and evokes the caregiver's feelings of having oneself been ignored, abused or unloved in the past (Fraiberg, Adelson & Shapiro, 1975).

Thus, learning to trust that the world is full of goodness, that grown-ups want to help you feel well fed, pacified, soothed and entertained—these are the legacies of quality caregiving over the first 12 months of life. The baby who has had such care will then accept a familiar outsider and feel free cheerfully to give orders to this "stranger" and submit to diapering and feeding. If the baby has not had consistency of care or if the adult has ministered to the infant only when feeling like it and not in synchrony with infant needs, the baby's eyes may be lackluster. Stools may be loose, sleep may be disturbed and fitful rather than profound. The *economy of the body* tells whether the baby has learned to trust, know joy and feel assured and powerful enough to get needs met. Adults who can read a baby's body signals become more alert to the *needs* for the reparative therapeutic nursery care so much needed by some infants (Fraiberg et al., 1975). By 7 months, the baby of joy and trust-a-building will look at the self in the mirror, crow, pat and even lean forward to kiss the baby.

Language and Communications

Communication skills built during the first year of life should be actively encouraged (Honig, 1985). During the first 6 months, babies produce all the sounds of all the languages of the world. But by 9 months, usually, only those sounds and intonations are kept that are in the language of the cultural group to which the baby belongs. Babies 3 to 4 months old practice complicated consonant combinations such as *dlth* as well as the open, throaty vowel sounds of cooing. The early combination of an easy consonant such as *m, b, p, t* with an open vowel such as *uh* or *ih* or *ah* produces syllables which, when doubled, become early words for babies: *mama, papa, baba* (for *bottle* or *blanket*), *cacah* (for *cookie* or *cracker*), *ki* for *kitty, li* (for *light*) and so on. Thus, caregivers need to encourage these easiest doubled vowel-consonant combinations. Use them in "motherese" or baby talk in order to enhance the power and pleasure of the infant to achieve communicative successes. Babies are learning to interpret adult words and ask for wants: *ju* for *juice* or *num-num* for *food* or *baw* for *ball*. The power to name gives baby a sense of ego strength too. The 11-month-old who can imperiously call out *maw* (*more*) when finished with a small portion of yogurt and be rewarded by a caregiver's prompt compliance develops a sense of efficacy, of competency, that bodes well for future efforts toward language learning and intellectual mastery efforts.

Babies enjoy book reading during the day and especially as a calming, cuddling activity just before naps. By one-half year, some babies are so used to being read to that getting baby to sleep without a long read of *Goodnight Moon* might be difficult for an unknowledgeable babysitter who tries! Pointing to pictures in books is a skill that 9-month-olds enjoy. They may also name pictures. It would be wise for the caregiver to remember that *wow-wow* said delightedly by a 9-month-old to whom a caregiver is showing a nursery rhyme book with Little BoPeep's sheep is just fine. Nine-month-olds should not be corrected as to the animal classification of Mary's little lamb. Some easy naming and pointing activities for babies at this age include cats, babies, dogs, balls, face and body parts and familiar pictured household events. Babies love to browse over and over through a scrapbook of their precious family members. This scrapbook too can help ease the sorrow of separation for babies in group care (Honig, 1980).

Interactive communication games are much enjoyed by babies from birth onward (Honig, 1982). Babies love to have a caregiver burble on a tummy or play "This little piggy goes to market" with toes and tickles. Babies love an adult to croon and sing to them. By 8 months they can bounce their buttocks in rhythm to a drum beat, music and chanted nursery rhymes. They appreciate having an adult lead their hands through the motions of "Pat it and mark it and put in a pan" and stretching out their arms for "So big!" They participate delightedly in varieties of peek-a-boo games, first by being alert and smiling, and later by pulling a cloth off their own and/or an adult's face and still later by active initiation of the game. Babies enjoy being bounced on a lap to a horsey game, while the "horsey" pretends to ride slower or faster (Honig & Lally, 1981). Raucous or frenzied music is overstimulating for babies.

Early sound and language communication is critical. Babies only a few weeks old can already participate in games of cooing turns. Talk while you are diapering and carrying out ordinary everyday care routines. *Turn-taking talk* becomes more and more important as infancy advances. Babies learn that they are important partners in these early conversations. The adult elicits infant coos, and later the baby jabbers earnestly in jargon and babbling to this interested caregiver. Wait: give baby a chance to respond to your talk. Babies need to learn that their communications are important, that they are competent partners in talking games. Their sense of mastery in language increases their pleasure in early language activities. They become zestfully motivated to master decoding verbal communications and encoding requests, comments and labeling. As babies earnestly jabber and point and change intonations trying to communicate with you, use techniques of *joint attention*. Notice what the baby points to, refers to or requests. Thus, by your validation of the importance of early preverbal vocalizations you can encourage the early emergence of words and enhance babies' pleasure in their emerging language powers.

By 1 year, babies imitate many sounds, say some single words such as *dada* and *doggie*, can adjust to words and gestures of their special adults and enjoy books. They are on their way toward becoming sophisticated decoders of vocal signals and have begun to participate actively in the symbolic signal system of language and to tackle early understanding of the rules by which creative language mastery is accomplished. Language learning is a peculiarly human and urgent development of the early years. Caregivers must nourish this learning as assiduously as they nourish bodies with food and comfort.

Conclusion

At 12 months of age, the cusp of joy most babies enter upon represents a crescendo and apex of the accomplishments of the first year. Baby is splendidly vertical, if wobbly. With pointing finger and assured babbles and even some single words, he or she can manage to get attention from and needs met by nurturing adults. Caregiver patience, admiration, oft-repeated harmonious routines, turn-taking talk and body cuddlings have given a deep bodily meaning to life. The cherishing and loving kindness of caregivers build a sturdy budding ego strength within the baby, who greets with sparkling eyes the threshold of the second year of life.

Continued on p. 22

References

Ainsworth, M.D.S. (1982). Early caregiving and later patterns of attachment. In M.H. Klaus & M.O. Robertson (Eds.), *Birth, interaction, and attachment* (pp. 35-43). Skillman, NJ: Johnson & Johnson Baby Products.

Bretherton, I., & Waters, E. (Eds.). (1986). Growing points of attachment theory and research. *Monographs of the Society for Research in Child Development, 50* (1-2, Serial No. 209).

Caldwell, B.M., Wright, C., Honig, A.S., & Tannenbaum, J. (1970). Infant day care and attachment. *American Journal of Orthopsychiatry, 40*, 397-412.

Erikson, E. (1950). *Childhood and society*. New York: W. W. Norton.

Fraiberg, S., Adelson, E., & Shapiro, V. (1975). Ghosts in the nursery: The problems of impaired mother infant relationships. *Journal of the American Academy of Child Psychiatry, 14*, 387-421.

Greenspan, S., Nover, R.A., & Scheuer, A.Q. (1986). A developmental diagnostic approach for infants, young children and their families. In A.S. Honig (Ed.), *Risk factors in infancy* (pp. 85-148). London: Gordon & Breach Science Publishers.

Honig, A.S. (1980). Early separation: Working with parents as a team. *Scholastic Pre-K Today, 4*(l), 46, 48-50.

Honig, A.S. (1981). What are the needs of infants? *Young Children, 37*(1), 3-10.

Honig, A.S. (1982). Infant-mother communication: Research in review. *Young Children, 37*(3), 52-62.

Honig, A.S. (1983). Meeting the needs of infants. *Dimensions, 11*(2), 4-7.

Honig, A.S. (1985). The art of talking to a baby. *Working Mother, 8*(3), 72-78.

Honig, A.S. (1989). Quality infant/toddler caregiving: Are there magic recipes? *Young Children, 44*(4), 4-10.

Honig, A.S. (1990). Infant/toddler education: Principles, practices, and promises. In C. Seefeldt (Ed.), *Continuing issues in early childhood education* (pp. 61-105). Columbus, OH: Charles E. Merrill.

Honig, A.S., & Lally, J.R. (1981). *Infant caregiving: A design for training*. Syracuse, NY: Syracuse University Press.

Honig, A.S., & Oski, F. (1986). Solemnity: A clinical risk index for iron deficient infants. In A.S. Honig (Ed.), *Risk factors in infancy* (pp. 69-84). London: Gordon & Breach Science Publishers.

Kaplan, L. (1978). *Oneness and separateness: From infant to individual*. New York: Simon & Schuster.

Leboyer, F. (1976). *Loving hands*. New York: Knopf.

Piaget, J. (1952). *The origins of intelligence in children*. New York: International Universities Press.

Winnicott, D.W. (1987). Babies and their mothers. Reading, MA: Addison-Wesley.

The Second Year: 12 to 24 Months

Kathryn Castle
Oklahoma State University

"Go! Go! Go!" Eighteen-month-old Amy's bright eyes reflect a powerful sense of independence as she pushes the wheeled laundry cart, almost larger than herself, across the floor. Who says young toddlers have short attention spans? Amy had just spent the last 30 minutes pushing the cart from one end of the room to another in what her mother viewed as endless repetition. Filled with a sense of personal power, Amy was totally engaged in leaning her weight against the cart, making it glide along the floor. Amy's mother, content in her assessment that the floor was safe for Amy's exploration, did not interrupt but made occasional suggestions such as, "Dolly go for a ride?" She kept her words close to Amy's, encouraging her to answer, "Dolly go!"

Developing a sense of independence within the warmth of a strong, nurturant toddler-caregiver relationship consumes most of the young toddler's waking hours during the second year of life. It is a time filled with developmental changes as dramatic as those of the first year. Increasing mobility opens up opportunities to explore, plus new limits to behaviors and the beginning of child-caregiver negotiation of these limits. If the limits are too strict, the toddler may become fearful or less curious about how things work. With the exertion of his or her new identity and the growing awareness that others see things differently, language begins to emerge as a tool for influencing and being influenced.

"No! No! No! Me do it!" is an example of this new assertive but fragile self who sometimes means "Yes" but says "No!" because it is more important to be powerful, even if it means saying "No" to ice cream! The caregiver may be perplexed when the toddler crumples in tears, getting his or her way but no ice cream! The second year is a balancing act between extremes, wanting to be independent but at times needing to be babied. It is also a balancing act for the caregiver who must be in tune with the young toddler's vacillating moods, knowing when to be firm and when to comfort. Living with a toddler can be exasperating, frustrating and exhausting but also joyous, satisfying and energizing. All constituents of quality care for babies continue to be important during the second year, especially a warm, nurturant, consistent caregiver who knows when to let go and when to hold on.

Doing and Learning

The word that best describes toddlers is "busy." Young toddlers are active constructors of knowledge who spend most of their time busily exploring wholeheartedly what is around them, especially with hands and mouths. Although they can spend long periods on one activity, more often they move very quickly from one thing to another. Their need for moving around brings them in contact with a variety of objects.

Toddlers learn about the properties of objects and how objects work by touching, mouthing, banging and throwing. Objects that do interesting, visible and audible things when handled make it easier to develop cause-effect connections. The feedback a toddler gets from a toy that rattles, rings, buzzes, moves, flutters, shines or smiles as a result of manipulation helps the child learn that a certain action results in a corresponding interesting event. Repeated experiences with cause-effect relationships lead to goal-directed behavior, such as pulling a string to get an object attached to it or turning a bowl upside down to use as a step to reach another object.

One of 20-month-old Jordan's favorite activities is playing at the water table, which reminds him of bath time at home. He uses his hands to splash, scoop and pat the water. He fills a large plastic bucket with water, then pours it toward himself to watch what the water will do. With a small sponge he washes cups and plates as he has seen his parents do at home. By the end of the second year, the toddler will imitate many adult activities and can visualize and imitate objects not present, such as swinging his arm in trunk fashion as he saw an elephant do the day before (Langer, 1986).

The second year of life is an important time for furthering the development of purposeful, intentional behavior, cause-effect relationships and the ability to solve simple problems, such as how to get one object from inside another (Castle, 1985). Eighteen-month-old Lori had been rolling a ball around the floor when she noticed a flat-based, hand-cranked spinning top that had inside it a visible red ball covered by transparent plastic. She picked up the top from a low table and threw it to the floor, looking surprised when it didn't bounce or roll. A nearby caregiver did not say "No!" or "We don't throw toys," but instead, "Push down," and showed Lori how to place her hand and push the handle to make the ball spin. With a satisfied expression, Lori imitated her hand movements and made the top work. After a moment, she went back to rolling and bouncing the ball, alternating this with pushing the top's handle to spin the ball inside.

Young children who learn through their actions how to influence the environment and cause change to occur will develop the concepts, "I can make something happen. I make a difference." A warm, loving caregiver and a responsive environment promote competency in problem-solving. Young children from unresponsive, overly restrictive environments are not as likely to develop goal-directed behavior as children who have had opportunities to use objects to influence events.

Program Implications

Toddlers need as much freedom as safely possible for exploring the environment. Routinely changing the assortment of toys, except for the most popular ones, maintains interest and sustains involvement. Encourage the young toddler to use new emerging skills to figure things out. If he or she becomes overly frustrated, lend a helping hand. Care should be taken not to impose an activity an adult thinks is appropriate over one a child chooses. Toddlers will create their own problems to solve when given a great variety of audio-visually responsive toys that do interesting things when manipulated, such as chime balls and toys with parts that disappear and reappear. Safe, lightweight blocks encourage grasping, lifting, stacking and feelings of mastery.

Twenty-four-month-old Adam was excited and self-satisfied after stacking several large, lightweight cardboard blocks together. He summoned a caregiver over to share his accomplishments. His caregiver expressed her excitement with, "Look at

© 1990 Michael Tony—TOPIX

the blocks! You stacked them up!" When caregivers show an active interest in the child and the activity, the toddler develops the idea he or she is valued and competent.

Young toddlers enjoy stacking and knocking down a variety of objects and filling and emptying containers. They usually have more interest and skill in throwing objects, knocking them down and scattering them than in stacking or gathering them up. Such activities give them much-needed practice of gross motor skills plus a sense of mastery and control over objects. Large, lightweight objects, such as cardboard blocks and inflatables, are popular with toddlers who feel powerful carrying objects almost as large as themselves. Toddlers are also fascinated with opening and closing drawers and hinged objects, such as doors, books and box lids.

Ideas About Self and Others

Babies develop a sense of self or self-permanence by about 8 to 9 months of age (Lewis, 1987), through which they understand that they are not a part of their caregiver or the environment but separate individuals. During the second year, this sense of self makes possible more complex social cognitive processes such as empathy and sharing, which are critical to the formation of relationships. Although toddlers are very egocentric and see the world only from their own needs and wants, they are capable of sharing in another's misfortune, such as 14-month-old Kara who put her arm around a fellow toddler who had fallen and bumped his head and offered him a most prized blanket.

This new self-identity is accompanied by the emergence of self-consciousness characterized, for example, by embarrassment in front of a mirror. During this period (about 12-18 months), the child's use of "No" and fear of loss of the caregiver become intense, indicating a clear understanding of the difference between self and others. In group care, separating from the parent can be most distressful. Sensitivity to a toddler's need for comfort during these times is critical. Toddlers who bring blankets, stuffed animals, family photos or familiar toys from home often turn to these objects for comfort to reduce the stress of separation. Every attempt should be made by parents and alternate caregivers to comfort and reassure them that parents will return. Established routines and mention of the order of events such as, "Mommy will come after nap," are sometimes helpful.

As language emerges, the young toddler begins verbally to share experiences with others. Old issues of attachment and autonomy can be renegotiated on a verbal level. During the last half of the second year, the toddler begins to learn what behaviors the caregiver finds acceptable and unacceptable and is developing "normative" standards (what is acceptable) through communications with the caregiver and "mastery" standards (goals to be attained) through acting on objects (Kagan, 1981). Caregivers who say "No" too much can create uncomfortable feelings of incompetence in exploring toddlers. When a toddler begins to hit another toddler's head with a plastic toy phone just to see what will happen, the caregiver can model a more positive interaction by offering the phone and saying, "It's for Sarah. Sarah want to talk?" Or the caregiver might redirect the toddler by offering another toy or activity. It is much easier for any toddler to learn the limits of behavior within the security of a warm child-caregiver relationship.

In personalizing care for young toddlers, the caregiver must appreciate their individual differences in tempo, energy, sociability and emotional arousal. Easy-going toddlers tend to be more sensitive to positive environmental stimulation while more difficult toddlers may be more sensitive to negative ones. The caregiver must

be able to tune into a toddler's individual rhythms, needs and preferences. For example, although adult caregiver Marsha was eager to play with the three toddlers in her care, she could sense by David's sleepy eyes and slumped body posture that David needed to relax. While she rocked him to sleep, she watched Michael fill and dump a plastic basket of toys and Andrea call "Mommy" on her toy telephone. When David was comfortably asleep in his crib, Marsha pretended to talk on the phone with Andrea. Then Michael plopped into Marsha's lap with a favorite book, which Marsha read to the two of them.

Attachment and Child Care

The infant-caregiver attachment sets the stage for subsequent relationships. A good attachment promotes a sense of general well-being and worthiness while facilitating cognitive growth. Young toddlers assessed as securely attached to their mothers at 18 months were found to be more enthusiastic, persistent, cooperative and effective at 24 months than insecurely attached toddlers (Matas, Arend & Sroufe, 1978). Toddlers with a good attachment to a caregiver are able to use the caregiver as a security base from which to explore the environment and learn about the world. Toddlers are capable of making multiple attachments with family members and child care workers. Consistency of caregivers is critical to the development of self and ensures that caregivers will get to know a child well enough to be responsive to individual differences in temperament.

Responsiveness in caregiving has been described as sensitivity in responding warmly and consistently to a child's signals (Bell & Ainsworth, 1972). High-empathy individuals are likely to be more emotionally responsive to a toddler's needs (Wisenfeld, Whitman & Malatesta, 1984). Caregivers must understand the toddler's need for security from adults and the need to defy adult authority. Vacillations between asserting their separateness from the caregiver and needing love and reassurance call for an understanding caregiver who sets reasonable limits and enforces them in a warm, compassionate manner, one who is there to offer a hug when needed but easily lets go when the child is ready to move on. These responses involve synchrony—harmonious, reciprocal, give-and-take interactions (Gonzalez-Mena, 1979).

When the child-mother attachment is inadequate, compensation may occur in attachment relationships with peers and alternate child caregivers (Howes, Rodning, Galluzzo & Myers, 1988). Alternate caregivers can encourage a positive child-parent attachment through sharing daily information about the child, working cooperatively on problems that may arise, emphasizing the importance of family in the program, planning special family activities and inviting parents to participate in the program.

Peer Interactions and Play

As early as 6 months infants are capable of interacting with peers. But these interactions are not as sustained or complex as those that occur during the second year. Certain types of infant interactions with their mothers may enhance subsequent social interactions with peers. Infants' turn-taking exchanges with their mothers have been found to lead to more extensive turn-taking interactions with peers (Vandell & Wilson, 1987).

❑ Without releasing his own grasp on his small toy bear, 12-month-old Chris placed it in his mother's hand saying, "Here!" His mother responded with, "Thank you."

Then Chris took the bear away also saying, "Thank you," and repeated the sequence several times. It was as if Chris wanted to give his mother an important gift, but wanted to have it for himself as well.

❑ Eighteen-month-old Elizabeth climbed on top of a slide and began to play with a plastic doughnut-shaped toy attached to the slide by an elastic streamer. Nineteen-month-old Tony tried unsuccessfully to grab the toy from Elizabeth who drew it back toward herself. Tony then climbed the slide and sat next to Elizabeth. She pulled the toy, then let it drop into Tony's lap. Tony picked it up, turned it over and handed it back to her. They exchanged the toy several times until Elizabeth climbed down the steps and toddled over to the water table, leaving Tony alone with the toy.

Peer interactions in young children have been linked to the promotion of cognitive growth and the ability to take the point of view of another (Castle & Richards, 1979). Peer play during the second year is characterized by conversations, turn-taking, empathetic behavior and the invention of spontaneous games (Wolf, 1982). Peer interactions may also promote the construction of physical knowledge and problem-solving skills. Reciprocal social exchanges with other children promote imitation, analysis of relationships and subsequent problem-solving behavior (Verba, Stambak & Sinclair, 1982). Young toddlers carefully observe the actions of other toddlers, imitate these actions with objects and solve simple problems that the observed child may not have solved. Imitative behaviors of one toddler lead to new variations of the behaviors in other toddlers. Very young children are capable of extracting meanings and relationships from the observed actions of other children.

❑ Twenty-three-month-old Ryan watched as his toddler friend Jacob tried unsuccessfully to remove a small plastic toy from inside a larger plastic hollow toy that had variously shaped holes. Jacob tried to get his hand inside one hole, then another, to reach the toy. He finally tossed it on the floor and began to play with a jumbo peg set. Ryan picked up the discarded toy and tried also to remove the smaller piece inside with his hand, but it would not fit into the holes. Then he turned the toy slowly, watching the movement of the piece trapped inside until it dropped out on its own through one of the holes. Ryan quickly pushed the piece back inside and repeated the action until it dropped out again. Jacob saw what happened and said, "Me do it!"

Toddler peer interactions are important for both social and cognitive development. If toddler group size is too large, however, interactions with other toddlers may become overwhelming and confusing. A sensitive caregiver intervenes when toddlers become too aggressive and harmful to one another, as in disputes over toys. It is difficult for toddlers to share toys because of their inability to see another's point of view, and thus it is developmentally inappropriate to expect them to. Rather, caregivers should provide plenty of duplicates of favorite toys, redirect aggressive behaviors, encourage children to see the other point of view and model cooperative behavior and other social skills.

Stages in exploratory play have been identified in children from 7 1/2 to 20 months of age (Belsky & Most, 1981). Their sequence goes from mouthing toys and handling them to using them the way they were intended (blocks for stacking) and using them with other objects (dolls placed on blocks) to pretend play (a block becomes a car). Play during the second year of life is meaningful in a developmental

sense, promoting friendship bonds among toddlers. Play probably becomes more meaningful, however, during the third year of life as language becomes increasingly more important in peer communications.

Caregivers should support and expand play while encouraging toddlers to take the lead (Eheart & Leavitt, 1985). Examples of expanding play would be adding props to play areas, asking open-ended questions about the play, describing the play and suggesting new ideas. Expanding play should not turn into lessons that may undermine toddler independence or interrupt a child's play. Rather, caregivers should avoid dominating toddler play while being available to participate when needed. Both the complexity level and the length of play may be increased when caregivers actively participate by verbalizing and making supportive suggestions (Slade, 1987).

A Quality Environment

The quality of the child's exploratory play is greatly influenced by the environment. Young children derive the most benefit from an environment they can structure through spontaneous, self-initiated activity rather than adult-structured situations. "In other words, caregivers should plan many opportunities for each baby to generate responses to his or her own exploratory play rather than simply to be stimulated by others" (Caruso, 1988, p. 68). Young children in responsive environments are more likely to grow socially and cognitively; such environments enable positive, reciprocal relationships with caregivers who provide open space with visible and accessible materials that invite exploration.

The most important ingredients of a quality environment include a warm, responsive caregiver, safe facilities and materials, freedom to explore within reasonable boundaries and responsive accessible toys, which do interesting things when manipulated (Castle, 1983). Environments for young toddlers (12 to 24 months) should include equipment to crawl inside, over, under and around; toys to push, pull and carry; and things to ride, roll and use to imitate adult activities. Children need a balance of activities that encourage large muscle activity (climbing) as well as fine motor control (putting a toy in a shape box). There should be open as well as private but supervised spaces. Materials should promote sense pleasure play (such as toys of different textures), expressive (musical toys), constructive (block-building) and pretend play (large-size adult props). Interest centers for toddlers may include areas for manipulation, construction, exploration of books, gross motor activities, water play, expressive art, rest and pretend play. The outdoor environment should be just as inviting as activities indoors and include nature walks, swings, wheeled vehicles such as wagons for pushing and pulling, sandbox, water play and climbing equipment.

Toys for toddlers are meant to encourage the development and use of emerging skills. Young toddlers beginning to climb will benefit from climbing equipment. Toys should invite children to be active and also stimulate the various senses and both sides of the brain, such as toys for hearing—music boxes, clocks, records, bells—and toys for seeing—mirrors, displays, an aquarium (Brooks & Obrzut, 1981). When a toy is first introduced, free exploration should occur without adult assistance to allow the toddler to find on his or her own several possibilities for play. Once interest is lost, caregivers may help the child find new play possibilities in the toy. Activities, toys and equipment ought to be replaced as children's interests and developmental needs change.

Quality in Group Care

While the controversy continues over the effects of group care on very young children, the demand for infant/toddler group care is increasing. What we know about quality programs is sufficient to help guide program designers. Early childhood professionals agree that quality indicators include a low child/adult ratio (not more than 3 to 4 toddlers per caregiver), caregiver continuity and caregiver training in child development/early childhood education (Honig, 1985; Howes, 1986). While many of these quality indicators are further elaborated on in the chapter on infant day care by Kelley and Surbeck, caregiver behaviors considered crucially important include:

- Talking about the effects of the child's behavior on others
- Encouraging problem-solving, such as looking for a hidden toy
- Emphasizing cooperation and altruism through modeling, cooperation, empathy and kindness
- Giving simple choices, such as choosing between two toys, snacks or activities
- Behaviors showing patience, such as allowing time for a child to wipe his or her own nose or pull off socks
- Behaviors showing humor, such as smiling, laughing and finding humor in everyday situations.

A caregiver communicates respect for a young toddler's personal dignity; for example, by approaching from the front to put on an apron or wipe a runny nose, rather than startling the child by coming up from behind and reaching around. The caregiver may also patiently encourage the child to try putting on the apron and blowing his or her own nose. Toddlers love to do things themselves; with proper guidance they can do a great many things.

Professional organization guidelines helpful in designing and implementing programs and communicating program goals to others include: 1) the Association for Childhood Education International (ACEI) position paper *The Right to Quality Child Care* (1988); 2) the Southern Association on Children Under Six (SACUS) position statements on quality child care and supporting parents (1986); 3) the National Association for the Education of Young Children (NAEYC) *Accreditation Criteria Procedures of the National Academy of Early Childhood Programs* (1984) and *Developmentally Appropriate Practice in Early Childhood Programs Serving Children from Birth Through Age 8* (Bredekamp, 1987). The latter contains chapters on "Developmentally Appropriate Care for Children from Birth to Age 3" and "Integrated Components of Developmentally Appropriate Practice for Infants and Toddlers." These guidelines call for caregiver modeling of language, respect for toddler-initiated play, flexible time schedules responsive to individual needs, treatment of routines like toileting as learning experiences, encouragement of exploratory indoor and outdoor play and an attractive, responsive, safe environment. The guidelines emphasize that toddler programs should be developmentally appropriate and individualized, not scaled-down versions of preschool programs.

Family Support

Quality programs should promote ways to strengthen the parent-child attachment relationship and parenting skills. Center caregivers and parents will benefit from joint efforts to promote optimal development in the child. Programs that sensitively address the needs of parents will help families to function successfully.

Group care for young children is ideally perceived as a complement rather than a substitute for parental care. Strengthening the family and encouraging positive attachments between child and family ought to be major goals of an infant/toddler program. Examples given by Schwartz (1983) for building bridges between home and program include: positive attitude of caregiver toward family diversity, informal and formal contacts with families, parent bulletin boards, policy advisory committees, workshops and discussion groups, social activities, conferences and daily information sheets.

Parent-caregiver interaction helps by "bridging the discontinuities between children's home and group experience; affirming and reinforcing the parents' natural role as primary caregivers; and providing advice and assistance, when appropriate, on the care of very young children" (Schwartz, 1983, p. 180).

Head Start experiences have taught that when programs work cooperatively with families, parents become better teachers and advocates for their children. The state of Missouri, in its Parents as Teachers (PAT) Program, found that the earlier parents are involved in programs for children, the more likely they are to continue to be involved as the child progresses through school. In the PAT Program (1988), new parents become involved with the schools before their child's birth and continue their participation through:

- Personal home visits by a trained parent educator who provides parenting information, toys and modeling of play interactions
- Group meetings with other parents where concerns and experiences can be shared
- Regular screening and monitoring of the child's development
- Referrals for special assistance, such as medical or financial help.

Caregivers in quality programs understand that parents are the major influence in their children's lives and support parents through sharing information and communicating the importance of the family-center partnership.

Conclusion

Twenty-four-month-old Clint smiles at himself in the mirror with clear, shining eyes that reflect his knowledge of himself as a happy, friendly, competent person able to make things happen; he knows how to get help from others in getting his needs met.

He has mastered the skill of getting from one place to another. He can run, jump, climb and walk backward. He can throw a ball and sometimes catch it. He loves to "read" books, open and close drawers and take his shoes and socks off.

He calls himself by name and knows the names of the other important people in his life. He is strongly attached to parents and has a good, warm relationship with his alternate caregiver. He uses words and simple sentences to communicate his thoughts, feelings and needs. He has developed the idea that he is a loved and valued person and feels good about himself and others. He is energetic and eager to meet the new experiences coming his way during his third year of life.

References

Association for Childhood Education International. E.E. Gotts. (1988). Position Paper. The right to quality child care. *Childhood Education, 64*, 268-275.

Bell, S.M., & Ainsworth, M.D. (1972). Infant crying and maternal responsiveness. *Child Development, 43*, 1171-1190.

Belsky, J., & Most, R.K. (1981). From exploration to play: A cross-sectional study of infant free play behavior. *Developmental Psychology, 17,* 630-639.

Bredekamp, S. (Ed.). (1987). *Developmentally appropriate practice in early childhood programs serving children from birth through age 8.* Washington, DC: National Association for the Education of Young Children.

Brooks, R., & Obrzut, J. (1981). Brain lateralization: Implications for infant stimulation and development. *Young Children, 36*(3), 9-16.

Caruso, D.A. (1988). Play and learning in infancy: Research and implications. *Young Children, 43*(6), 63-69.

Castle, K. (1983). *The infant & toddler handbook.* Atlanta, GA: Humanics Limited.

Castle, K. (1985). Toddlers and tools. *Childhood Education, 61,* 352-355.

Castle, K., & Richards, H. (1979). Adult/peer interactions and role-taking ability among preschool children. *Journal of Genetic Psychology, 135,* 71-79.

Eheart, B.K., & Leavitt, R.L. (1985). Supporting toddler play. *Young Children, 40*(3), 18-22.

Gonzalez-Mena, J. (1979). What is a good beginning? *Young Children, 34*(3), 47-53.

Honig, A. (1985). High quality infant/toddler care: Issues and dilemmas. *Young Children, 41*(1), 40-46.

Howes, C. (1986, April). *Quality indicators for infant-toddler child care.* Paper presented at the annual meeting of the American Educational Research Association, San Francisco, CA. (ERIC Reproduction Service No. ED 273 385)

Howes, C., Rodning, C., Galluzzo, D.C., & Myers, L. (1988). Attachment and child care: Relationships with mother and caregiver. *Early Childhood Research Quarterly, 3,* 403-416.

Kagan, J. (1981). *The second year.* Cambridge, MA: Harvard University Press.

Langer, J. (1986). *The origins of logic one to two years.* New York: Academic Press.

Lewis, M. (1987). Social development in infancy and early childhood. In J. Osofsky (Ed.), *Handbook on infant development* (2nd ed.) (pp. 419-493). New York: John Wiley & Sons.

Matas, L., Arend, R.A., & Sroufe, L.A. (1978). Continuity of adaptation in the second year: The relationship between quality of attachment and later competence. *Child Development, 49,* 547-556.

National Association for the Education of Young Children. (1984). *Accreditation criteria procedures of the National Academy of Early Childhood programs.* Washington, DC: NAEYC.

Parents as Teachers. (1988). St. Louis, MO: Marillac Hall, University of Missouri-St. Louis, 8001 Natural Bridge Road, 63121.

Schwartz, J. (1983). Implications from research for infant/toddler group care. *Child Care Quarterly, 12*(3), 177-198.

Slade, A. (1987). A longitudinal study of maternal involvement and symbolic play during the toddler period. *Child Development, 58,* 367-375.

Southern Association on Children Under Six. (1986). *Position statement on quality child care; Position statement on supporting parents.* Little Rock, AR: SACUS.

Vandell, D.L., & Wilson, K.S. (1987). Infants' interactions with mother, sibling, and peer: Contrasts and relations between interaction systems. *Child Development, 58,* 176-186.

Verba, M., Stambak, M., & Sinclair, H. (1982). Physical knowledge and social interaction in children from 18 to 24 months of age. In G. Forman (Ed.), *Action and thought from sensorimotor schemes to symbolic operations* (pp. 267-296). New York: Academic Press.

Wisenfeld, A.R., Whitman, P.B., & Malatesta, C.Z. (1984). Individual differences among adult women in sensitivity to infants: Evidence in support of an empathy concept. *Journal of Personality and Social Psychology, 46,* 118-124.

Wolf, D. (1982). Understanding others: A longitudinal case study of the concept of independent agency. In G. Forman (Ed.), *Action and thought from sensorimotor schemes to symbolic operations* (pp. 297-327). New York: Academic Press.

Toddlers: 24 to 36 Months

Nancy Balaban
Bank Street College Graduate School of Education

❑ The children have finished playing with soapsuds, and the teacher begins to use a large sponge to clean up the table. Two-year-old Harry roughly pushes the teacher's hand away from the sponge and grabs it. "Gimme! I do it!" he shouts. "You're washing the table yourself," the teacher comments gently.

Working with 2-year-old toddlers in a group setting is as demanding as working with younger toddlers. Despite Harry's provocative grabbing, his teacher obviously understood and encouraged Harry's passion to be competent. If asked, she'd say, "Twos are like that!" It is a great challenge to early childhood professionals to provide personalized care for 2-year-olds fashioned around their very particular toddler needs. In order to be familiar with what 2-year-olds are like, we will enliven these pages with the doings of some real 2-year-olds. At the same time, we will construct program elements "to fit." While the previous chapter focused on the young toddler, this chapter will explore development and program considerations for older toddlers. This is not as simple as it sounds; most early childhood professionals have been educated within the preschool frame, an uncomfortable fit for working with 2-year-olds. Devising a personalized program for them requires new ways of thinking.

LOOKING AT 2-YEAR-OLDS: THINKING ABOUT PROGRAMS

A Time of Strong Attachment to Parents

When we say we work with 2-year-olds, we really mean that we work with 2s and their parents because 2-year-olds' attachment to their parents is the central, most important characteristic of children this age; planning programs for them must always include thinking about their parents. Twos and their parents do not take separation lightly. Their connection to one another is strong. Because 2-year-olds have a new realization of their own vulnerability, they know how much they need and depend on their parents. Separation fills a 2-year-old with grave apprehension. Most parents understand and enjoy this deep and growing tie to their 2-year-olds.

❑ Twenty-six-month-old Cassie and her dad and mom have walked to the elevator that takes mom to her office. Cassie clings to her mom. Cassie's dad, who will then take her to day care a block away, stands next to her. When the elevator arrives, her mom says good-by calmly and gets in. As the doors close, Cassie flings her stuffed bear to the floor, screaming. Her dad cradles her in his arms. She is still screaming as they walk out of the building.

Implications for Programs

Nurturing this strong parent-child bond is critical if the older toddler is to grow into a secure, lively, inquisitive person. Accepting and appreciating this allegiance must form the core of decisions about programs for 2s.

Toddlers and parents need time to separate from one another. Encouraging parents to visit a program without their child at first, if possible, gives them an opportunity to see the caregivers in action, observe how the toddlers in the group are doing and learn about the policies of the center. Parents need to know what happens when toddlers are negative, where they will nap, how lunch and snacks are arranged, how outings are accomplished and what will take place if the toddler gets sick. They need to know how the separation will proceed.

A slow and gradual entry for toddlers and parents works best. It allows the toddler time to accommodate to the new setting and the new caregiver, relieving the parents' concerns about the safety and well-being of their child. Such an entry helps the teacher learn about the toddler's special qualities, needs and language from the parent, who knows the child longer and better than anyone else.

A gradual entry acknowledges that the parent-child tie is central and significant. The slow entry accepts the fact that the toddler's reluctance to leave the parent and to feel sad, lonely and even angry is both normal and expected. Sometimes working parents, because of the nature of their jobs, can spend only a small portion of time helping their toddler adjust to child care. Then other creative measures must be taken. Phone calls from the parent to the child at the center or family day care home will reassure the toddler that the parent still exists and still cares. A photograph of parents for toddlers to hold, covered with clear adhering plastic, helps serve as a reminder that mom or dad will come back. An audiotape of the parent singing a favorite song or reading (or telling) a favorite story may bring comfort. Perhaps a parent can spend a few extra moments at pick-up time sharing the new environment with the toddler and exchanging information with the caregiver about such things as the toddler's sleeping and eating habits, the toddler's favorite home activities, the meaning of the toddler's words.

Helping toddlers and their parents separate and adjust to out-of-home care is a difficult task. A teacher can easily become distraught when a toddler, longing for the parent, cannot be comforted for long periods; in times of great stress toddlers do not have the adult's ability to keep in their minds the inner image of the loved parent. Toddlers in that state fear that "gone" means "gone forever." Panic sets in. Sometimes caregivers believe that to talk about the absent parent will only make things worse, but that is not the case. Indeed, toddlers need help to keep the parent in their minds as a source of comfort. They count on their teachers to reassure them that mom or dad always comes back.

In addition, teachers must also work with parents' feelings and worries about leaving their toddlers. Parents need reassurance that the caregiver will attend to their toddlers' needs. Sometimes parents may seem unreasonable, overanxious, demanding, disrespectful of the caregiver's job. These are times when a teacher's careful listening and ability to involve the parent in mutual problem-solving works better than defensiveness. "I can see that you are upset when Alex screams. Why don't you phone me in an hour and I'll let you know how he is," will be more successful than telling a parent to stop worrying. When teachers and parents cooperate to create a warm and caring environment, children feel protected and safe.

A TIME OF TRANSITION

Two-year-olds are no longer infants, but not yet preschoolers; they are in transition from one period of development to another. As in adolescence, this "in between" stage creates much turmoil for the toddler. Throwing off the dependence of infancy and marching toward greater independence engender inner conflict as well as outer conflict with others. We see it in toddlers in many familiar forms: opposition to adult demands, ambivalence in behavior, lack of impulse control, aggression, rigorous demands and lack of flexibility.

❑ The teacher has just mixed play dough with Keni, Ross and Jessica. They have put in some red food color. First she hands some to Keni. "Here's some red play dough for you." Keni pouts and begins to cry, "I don't want red." Ross and Jessica each take some red dough. Keni says, "I want red. "

Implications for Programs

Planning for children who can move quickly without thinking, who can speak but do not always understand, who are irrational, demanding, insistent, uncooperative, unpredictable, as well as loving, adorable, huggable, funny, sweet, charming, delightful and usually in motion requires a model closer to home (Prescott, 1978) than to school. At home the day flows loosely within a structure. Other people, like neighbors and the mail carrier, come and go; children play with household objects like pots and pans; they smell food cooking; they accompany their parents to the bank, the post office, the market. A home is full of soft things like rugs, pillows, pets and laps. There is the possibility of privacy.

Incorporating home elements into programs for these toddlers-in-transit means bending expectations that are appropriate for preschoolers, such as conforming to a "circle time" or sharing playthings. Stories read to 1, 2 or 3 toddlers rather than the whole group encourage a homey, intimate experience. Stories can be read whenever a 2-year-old, book in hand, plops into a teacher's lap; no need to wait for "story time."

Two-year-olds want to *do* just about everything *on their own*. Their inability to do what they think they can do is usually a source of great frustration and often rage. Being unable to tie a shoe or remove a lid from a box can bring on a stunning tantrum. But children this age have developed many new competencies. They can feed themselves, pour their own juice, solve problems, run and climb, blow their noses, undress quickly. Their emerging skills, however, frequently outdistance their judgment, and they might tumble down a flight of stairs, run into the street or touch a hot stove.

A group of toddlers is sometimes like popping corn, swirling, jumping, bumping, walking, prodding, poking, pushing, pulling, looking, tasting, laughing, crying. When one is up, another is down. When one is crying, another is laughing; when one is pushing, another is pulling.

Teachers need to be vigilant while simultaneously providing a broad and flexible day, full of interesting activities as well as opportunities for children to change their minds, switch directions, dabble as well as persevere. There must be enough to do, time to do it in and the chance not to do.

Toddlers need a consistent pattern to their day in group care in which familiar events predictably follow one another: a time for snack each morning and afternoon, a time for going outdoors, a time perhaps for singing together, a time for lunch, a time

for naps. And there should be lots of open time for exploration; for sitting in laps, looking out the window, hearing a story; for messing about in water, dough, paint and with blocks; for climbing and jumping; for conversation. And sometimes for doing nothing.

The secret here is the use of time that allows toddlers to start an activity of their choice and finish it at their own pace. A toddler engrossed in water play does not easily shift into another activity designed by the teacher.

This is best accomplished by breaking up the group into mini-groups during the day. As the sine qua non for quality group care, a total group should consist of no more than 10 2-year-olds with 3 caregivers. Because toddlers are so mercurial, the group—even the small total group of fewer than 10—can be overstimulating after too long a period of time, giving rise to biting, hitting, hair pulling and pushing. Mini-groups of 2 or 3 children and one adult add variation and relaxation to the day. Such subdivisions can be used both morning and afternoon to give children space and an opportunity for close person-to-person contact with the caregiver. While one group stays in the room for a story and water play, for example, another group goes outdoors for an exploring walk; the third group goes with a teacher to the post office to mail a letter, as they would with parents if they were at home. Such everyday experiences offer toddlers a wealth of information about how the world works.

A TIME OF PLAY AND LANGUAGE DEVELOPMENT

The 2-year-old is no longer the pointing, grunting baby but is beginning to develop language, thus making the transition to greater humanness. Stone and Church (1973) describe this so aptly:

> We must stress that the use of language is not an isolated skill, like eating with a spoon or riding a tricycle, but brings with it an all-pervasive transformation of perceiving, feeling, thinking and general intelligence. We might insist that it is only by becoming a linguistic organism, by understanding speech and by speaking, that the child gains access to full status as a human being. (pp. 216-217)

The companion of language is make-believe play. In some mysterious way the two abilities complement and encourage the development of each other. Each proceeds at its own pace within the unfolding of the individual child. Some toddlers are using two- and three-word utterances while others are producing whole sentences. Some are silently feeding the teddy bear and putting it to bed while others are beginning to engage in more complex symbolic play.

❑ Two children are already in the rocking boat when Sara comes along. "I want to get in," she says. They make room for her. As she gets in she tells the teacher, "I'm getting my feet out of the water."

Implications for Programs

Children of 2 learn to speak and play more when teachers believe that speaking and playing are valuable tools of childhood. Thus, adults should listen carefully to what children are saying or trying to say and respond appropriately. There is no need to "make up" an answer to what you think the toddler is saying. Rather, speak to the

E. Anne Eddowes

child as you would to an adult, "I can't understand what you mean. Show me what you're talking about so I can help you."

Respect for children's budding language implies the willingness to understand that, through speaking, children enter the adult world. They try out words heard from a variety of sources, some acceptable and others not.

❑ A caregiver told Genna to stop climbing up on the table. Genna glared at her and said, "Mind your own business!"

There are two possible adult answers here. One is, "That's not a nice way to talk," and the other, "What does 'Mind your own business' mean?" Chances are that the 2-year-old isn't really sure. This is a fine opportunity for the adult to both clarify the meaning and to help the child label her feelings. "You were really angry at me for telling you to get off the table. But we don't climb on tables here. You can climb on the big box in the yard."

Creating a "language environment" means speaking directly and clearly to 2-year-olds, commenting on their activity, their accomplishments, their new shoes, on anything related to their families. Two-year-olds are deeply rooted in themselves and in what they are doing. They enjoy hearing stories about themselves—a superb way of personalizing care and supporting burgeoning speech.

❑ "I'm going to tell you a story," the teacher tells Rebecca. "Once there was a little girl named Rebecca. She had a bear and a rabbit. She poured each one a cup of tea and they all sat down and drank their tea and ate their cookies. It was such a nice tea party." Rebecca says, "That's a story about me. I have a bear and a rabbit." Then Rebecca gives the teacher a cup of "tea" and they have a tea party together. [1]

Symbolic play flourishes when there are accessible props like hats, lengths of cloth, shoes, handbags, small suitcases, eyeglass frames (glass-less), along with dolls, stuffed animals, small beds, sink, stove, refrigerator and unpressured time. It is through play that children form friendships, test their ideas, sort out the nature of the world, try out new roles, exercise their budding language. They seldom need adult prompts to begin playing unless they have been reared in circumstances that make play a luxury. In such cases, the adult will need to actively engage the child in make-believe (Smilansky, 1968; Singer & Singer, 1977).

A TIME OF PRESSING PHYSICAL NEEDS

Toddlers, now that they are upright and self-propelled, have a new sense of themselves in space. They have intense needs to practice and exercise their large muscle skills. They need to climb, jump, run, hop, crawl, roll, slide and fit themselves into small corners, boxes and cubbies. They know where things are, but they do not know the boundaries. They may climb to the top of an open shelf to get an object that is appealing or walk away from a caretaker for the sheer joy of walking. Sometimes they are in constant motion. In a three-minute span of time this is what 28-month-old Eric did:

❑ He gathers up six soft foam cubes and marches up and down the room; drops them all and throws one at Emma; picks up a plastic, linked "snake" and curls it in the air as he climbs atop a wooden crate, then drops the snake on the floor; pulls down a pile of cardboard blocks and stands on one; piles them up in order to climb back on the crate; crawls on hands and knees atop the crate; stands and jumps off the crate onto a foam mat; watches the teacher who is singing with two children; walks on the mat to a crate at the other end of the mat and lies down; sees another child inside the crate and says, "Who in dere?" The other child peeks out, and they both laugh.

Implications for Programs

Because the early childhood model is so often used for programs for 2-year-olds, gross motor needs are frequently neglected in the classroom (Escalona, 1974). Homes, however, are full of opportunities for full body action: couches and chairs to climb into, stairs to traverse up and down, tables to crawl under.

Spaces for toddlers need to include: adult-sized furniture such as a couch or an easy chair, pillows for nestling in or jumping into, sturdy wooden crates or boxes for crawling into or jumping from onto thick foam mats. Vertical three- or four-rung ladders can be affixed to the wall for climbing. A soft seat swing can be attached to a ceiling beam. A low loft can be built to provide another level in the room as well as space for privacy and quiet. Barrel-like containers from sweeping compounds can be scrubbed and cleaned, covered on the outside with adhering plastic to provide perfect crawl-into, climb-out-of hiding spaces for 2-year-olds. Space and equipment for moving mean learning and growing at 2.

A TIME FOR PERSONALIZED CARE

Two-year-olds need adults who care about them, understand their inner turbulence, enjoy their unpredictability, can "go with their flow," don't mind disarray, and are accepting, playful and energetic. It is the adults in their lives like Annie in the following anecdote who bring meaning to them and define the world for them as safe, alluring, stimulating and loving.

❑ Annie calls to 24-month-old Jay who is still sitting on his cot after waking up: "Come to the bathroom so I can change your diaper." He pouts and says "No." He cries, hugs his sheet and runs out of the room to his cubby. He comes back, frowning, slowly goes to the bathroom and skillfully climbs on to the changing platform. He stands very close to Annie and plays with the buttons on her shirt. She chats with him about the morning's activities while she takes off his diaper. He begins to scratch a rash on his thigh. "Try not to scratch," Annie tells him. He points to the supply closet and says, "Eh, eh, eh, powder." Annie gets the powder and puts some in his waiting hand. He pats a little on himself.

Next she lays him down to put on the clean diaper. She leans close to his face and talks to him. Jay smiles, reaches up, grabs her hair and pushes it in front of her eyes. The two of them laugh. Jay then starts to play with Annie's face, saying nonsense words in a singsong way. After Jay is fully dressed he looks up at Annie, says "Kiss" and puckers his lips. She bends down her head and he kisses her cheek. She lifts him off the table and he shuffles away saying "Choo, choo, choo." [2]

Person-to-person care is what matters to 2-year-olds and their families. It is fundamentally crucial to toddlers' successful emergence into the preschool years.

References and Bibliography

Balaban, N. (1985). *Starting school: From separation to independence: A guide for early childhood teachers.* New York: Teachers College Press.

Balaban, N. (1988). Twos are not preschoolers. *Day Care and Early Education, 16*(1), 42-43.

Bronson, W.C. (1981). *Toddlers' behaviors with agemates: Issues of interaction, cognition and affect.* Norwood, NJ: Ablex.

Eckerman, C.O., Davis, C.C., & Didow, S.M. (1989). Toddlers' emerging ways of achieving social coordinations with a peer. *Child Development, 60,* 440-453.

Escalona, S. (1974). Developmental issues in the second year of life: Their implications for day care practices. *Psychosocial Processes, 3*(1), 28-42.

Gonzalez-Mena, J. (1986). Toddlers: What to expect. *Young Children, 42*(1), 47-51.

Haswell, K., Hock, E., & Wenar, C. (1982). Techniques for dealing with oppositional behavior in preschool children. *Young Children, 37*(3), 12-18.

Honig, A. (1982). Research in review: Language environments for young children. *Young Children, 38*(1), 56-67.

Honig, A. (1982). Research in review: Prosocial development in children. *Young Children, 37*(5), 51-62.

Johnson, H. (1972). *Children in "The nursery school."* New York: Agathon Press. (Original work published 1928)

Kagan, J. (1982). The emergence of self. *Journal of Child Psychology and Psychiatry, 23,* 363-381.

Leipzig, J. (1986). Fostering prosocial development in infants and toddlers. In D.P. Wolf (Ed.), *Friendship in the lives of young children* (pp. 27-33). Redmond, WA: Exchange Press.

Prescott, E. (1978). Is day care as good as a good home? *Young Children*, 33(2), 13-19.
Provence, S. (1977). The day to day experience for infants and toddlers. In S. Provence, *The challenge of day care* (pp. 90-144). New Haven, CT: Yale University Press .
Singer, D., & Singer, J. (1977). *Partners in play: A step by step guide to imaginative play in children*. New York: Harper & Row.
Smilansky, S. (1968). *The effects of sociodramatic play on disadvantaged preschool children*. New York: Wiley & Sons.
Stewart, I.S. (1982). The real world of teaching two year old children. *Young Children*, 37(5), 3-13.
Stone, J., & Church, J. (1973). *Childhood and adolescence* (3rd ed.). New York: Random House.
Stonehouse, A.W. (1982). The challenge of toddlers and discipline. In R. Lurie & R. Neugebauer (Eds.), *Caring for infants and toddlers*. Redmond, WA: Child Care Information Exchange.
Tyler, B., & Dittman, L. (1980). Meeting toddlers more than halfway: The behavior of toddlers and their caregivers. *Young Children*, 35(2), 39-46.
Van der Zande, I. (1986). *1,2,3...The toddler years: A practical guide for parents and caregivers*. Santa Cruz, CA: Santa Cruz Toddler Center.
Woodcock, L. (1941). *Life and ways of the two year old*. New York: E.P. Dutton & Co.

Reference Notes

[1] Anecdote by Kate Titone, (1989), student at Bank Street College, New York.
[2] Anecdote by Gloria Mattera, (1978), student at Bank Street College, New York.

Quality, Integrated Programs for Infants and Toddlers with Special Needs

David Sexton
University of New Orleans

One of American society's greatest challenges is providing quality care and education for its youngest citizens. Current estimates are that approximately 7,000,000 children are being cared for in family care homes or child care centers (Kontos, 1988). Infants and toddlers constitute about 30 percent of this population (Sells & Paeth, 1987; Vincent, 1988). As more and more mothers enter the labor market, the demand for infant care will continue to increase dramatically. Embedded within this large population of children receiving or needing out-of-home care are those infants and toddlers with handicaps, those experiencing developmental delay, and those considered at high risk for developmental delay or disability because of biological or environmental factors. In addition to the family's need for child care, such infants and toddlers also often need specialized interventions to minimize or prevent the limitations of disabling conditions, promote optimal development and enrich environmental contexts within which growth, development and learning occur.

Recognizing these facts, Congress enacted the Education of the Handicapped Amendments Act of 1986 (P.L. 99-457), amending P.L. 94-142. Part H of this act provides financial assistance to states for developing and implementing statewide, comprehensive, coordinated, multidisciplinary, interagency systems to provide early intervention services for infants/toddlers with handicaps and their families. This is the only grant program within the federal government that focuses exclusively on the provision of services to children with handicaps from birth through age 2. Each state has five years to develop a system that addresses at least 14 components to include a state definition of who is eligible for services, timetables for serving all eligible children, and policies and procedures related to maintenance of standards to ensure adequate preparation and training of personnel.

One extremely important provision of this law is the requirement that early intervention services, to the extent appropriate, be provided in the types of settings in which infants and toddlers without handicaps would participate. Hanline and Hanson (1989) defined this process of integration as opportunities for infants and toddlers with handicaps or delays to participate in community-based activities with their families and in social interactions with nondisabled children and their families. Such environments include day care programs, family care settings and nursery schools.

The widespread use of existing child care and early childhood education systems to serve infants and toddlers with handicaps will be, with some notable exceptions,

a new approach to providing services; children with special needs traditionally have been placed in special, segregated programs or served in home-based programs with parents serving as the primary interventionists. The task of integrating such babies into typical child care settings will be challenging for a number of reasons. First, many individuals mistakenly believe that the "special" needs of these children can and should be met only in "special" settings. Second, various rules and regulations prohibit or complicate reimbursement to private and public providers that could serve children with handicaps in "regular" child care programs. Finally, although evidence suggests that many day care centers are willing to accept children with handicaps into their program (Berk & Berk, 1982), some child and family care providers may be reluctant because of the excessive time and care such children might require. In addition, negative staff attitudes, increased insurance premiums and possible adverse reactions of parents of children without handicaps may interfere with this process.

Using existing child care and education programs as major resources in the development of comprehensive statewide systems is necessary if child care needs of many infants with handicaps and their families are to be successfully met. There are several questions central to the planning and decision-making processes occurring during the 5-year planning phase (1986-1991) of P.L. 99-457, Part H, and thereafter. These questions will influence the availability and quality of integrated infant and toddler services and must be addressed.

Who Should Be Eligible for Services?

Of the nearly 3.7 million infants born each year in the United States, approximately 1-2 percent or 55,000 infants will manifest a disabling condition at birth, with another 370,000 of these children developing a disabling condition within the first 4 years of life (Garwood, Fewell & Neisworth, 1988). In all likelihood, the number of children needing early intervention services will increase as medical advances save more severely handicapped children (Moore & McLaughlin, 1988), as the number of female-headed households with limited resources increases (Anastasiow, 1988) and as a greater number of infants are born with acquired immunodeficiency syndrome (AIDS) (Howard, 1989; Odom & Warren, 1988). These medical and health-related issues will be more fully addressed by Feeg in the next chapter.

P.L. 99-457, Part H, makes reference to 3 groups of infants and toddlers who potentially could be included in a state's definition of disability: first, children with a known or established handicapping condition such as Down syndrome; second, babies who exhibit delay in one or more developmental areas (it is up to each state to establish specific criteria for identification); third, infants at risk of developing a disability due to biological factors, such as low birth weight or environmental factors, such as parents who are substance abusers.

It appears that all states will address problems of those children with established handicapping conditions, while most states will define and serve infants and toddlers with developmental delay. Unfortunately, fewer states are including at-risk infants in their eligibility requirements, particularly those at environmental risk. The numerous advantages to including the at-risk population include: a) the facilitation of a more comprehensive, multiagency system, since a greater number and diversity of service providers would be affected and b) the movement of special education away from just serving children with existing handicaps to a philosophy of prevention (Graham & Scott, 1988). The major argument against making all three groups of

children eligible for services is the cost factor. For example, an inclusive definition could mean that approximately 45 percent of all families in the city of New Orleans could qualify as being environmentally at risk due to low income status alone. The short-term costs associated with an inclusive definition, however, must be weighed against the long-term potential benefits of lowered educational and social costs over many years and the cost reductions potentially available through expanded inter-agency coordination and collaboration.

Where Should Services Be Provided?

Presently, our primarily segregated service delivery systems are not meeting needs of infants and toddlers with known or suspected handicaps and their families. Some estimates are that only about 10 percent of infants needing specialized early intervention services are getting them (Garwood et al., 1988). How to serve such large numbers of infants, toddlers and families efficiently and economically is a real challenge.

One alternative service model to segregated center-based services for infants and toddlers with handicaps and their families is to rely on the parents to provide prescribed activities within the home under the direction of a home visitor. Integration opportunities could occur by planning interactions with nondelayed children and their families who are relatives, friends or neighbors. This approach will not be appropriate, however, for large numbers of families who also need extended child care due to work demands. A logical alternative is to use existing child care and education systems that serve primarily nonhandicapped children as integrated environments where special needs can also be addressed. The effective use of such services will require the blending of child care, education and special intervention services into the same program (Kontos, 1988). This blending not only will benefit infants and toddlers with special needs but also will result in improved services for children without handicaps. Mitchell (1989) made this point in the following manner:

> The misconception that early childhood education and child care can be discrete services is fast becoming a thing of the past. Programs for young children cannot be one or the other; any early childhood program provides both education and care. These two functions are inextricably bound together; children cannot be well cared for without learning, and they cannot be educated well without being properly cared for. (p. 66)

Are Best Practices Different for Infants and Toddlers If They Are Handicapped or Delayed?

It is hardly surprising that many indicators of best practice with infants who are not handicapped are also associated with quality services for infants with special needs. It is certainly true that one "quality" indicator of a program that serves young children is its ability to meet the developmental needs of a wide range of children considered typical (Howard, 1989). If a program cannot engage in developmentally appropriate practices with typical children representing a wide range of needs, then it is probably safe to conclude that such a program would also be inadequate for infants and toddlers with special needs (Galloway & Chandler, 1978).

In general, there is agreement that a low adult-infant ratio (usually defined as no more than 1 adult per 3 infants/toddlers) is a prerequisite for quality intervention and care of typical infants (ACEI/Gotts, 1988; Hignett, 1988; Honig, 1985). The integration of infants with special needs may be difficult if expectations are that there will be a 1:1 adult-child ratio. One major change in early childhood special education philosophy,

however, defines best practice for teachers or caregivers as taking advantage of naturally occurring environmental events and children's self-initiated activities as opportunities for interventions (Bricker, 1988). The movement away from contrived instructional activities and isolated "therapies" toward use of daily routines such as eating and dressing and child-initiated activities such as play (Fewell & Kaminiski, 1988; Widerstrom, 1986) within which to embed special interventions or therapies means that teachers and caregivers can effectively work with infants with special needs in ratios much like those associated with quality programming for infants and toddlers without handicaps or delays.

Another point of agreement is the crucial role families play in the care and education of infants and toddlers. This recognition has been embodied in P.L. 99-457 by the requirement of an Individualized Family Service Plan (IFSP) for each eligible family. This written document must include: a) infant's present levels of development, b) family strengths and needs related to enhancing the development of the infant, c) major expected outcomes for infant and family, d) specific early intervention services necessary to meet needs, and e) specification of a case manager who will implement and monitor the IFSP. This document (and accompanying process) is one formal way to encourage service providers to view infant needs within the overall context of the family.

What Are Some Considerations in Providing an Integrated Learning Environment for Infants and Toddlers?

Quality education and care for infants and toddlers can be provided only in environments designed and equipped for learning (ACEI/Gotts, 1988; Hignett, 1988). For the purpose of this discussion, environment is defined broadly to include objects, persons and all interactions. The integration of most infants and toddlers with mild handicapping conditions will require very little, if any, adaptation of the learning environment. The successful inclusion of infants and toddlers with more severe or multiple handicaps often does require some environmental accommodations. The type and number of specific adaptations will vary from child to child based on individual needs. Many such adaptations, however, will be surprisingly simple and inexpensive. Individuals desiring to determine the extent to which a specific environment promotes the development and learning of infants with handicaps should complete the 20-item checklist contained in the Appendix to this chapter, which was adapted from the work of Rikhye, Gothelf and Appell (1989). Although the original checklist was developed specifically for children with dual sensory impairments, it is also a good environmental planning guide for children with other handicapping conditions.

We often think of the environment in the context of things like toys, lighting, furniture and other inanimate objects. We must keep in mind the important roles *individuals* play in learning. In most child care and education settings, there will be both caregivers and other infants and toddlers.

Training Needs. To a large extent, the successful integration of infants and toddlers with handicaps will be a function of the responsiveness and knowledge of their caregivers. In addition to generic training related to developmental needs of infants and toddlers, staff members will require specialized training. Research conducted with day care providers serving children with handicaps has indicated that special training needs include behavior management techniques, strategies for including children with handicaps in ongoing activities and working with parents

(Klein & Sheehan, 1987). Additional training should be provided in the areas of communication skills, self-help skills, handling and positioning, medical management and the design and use of adapted equipment and materials. As caregivers develop confidence in their abilities to meet special needs, they also become more likely to interact with such children and their families in positive, supportive ways.

Importance of Communication. Consideration should also be given to techniques to encourage interactions between infants and toddlers with handicaps and their nonhandicapped peers. Making available certain types of toys and materials can increase the likelihood that positive interactions will occur. Such items as vehicles, doll houses and blocks promote interaction. Keep in mind, however, that peer-directed behaviors at this age consist primarily of looking, smiling, cooing and moving toward other infants and will occur with much less frequency than adult-directed behaviors.

Communication skills are intimately related to social development. That is, child-adult and child-child social exchanges are the contexts within which communication skills are learned. Many infants and toddlers with handicaps or delays often lack basic behaviors that can initiate or prolong interactions. Such babies are often hard to "read" in communication exchanges because they do not give or maintain eye contact, smile, coo or behave like other babies. Therefore, caregivers, parents and other adults need to understand that special strategies to promote communication skills are necessary.

Two important communication techniques appropriate for infants and toddlers with more severe handicapping conditions are object cues and touch cues. Object cues provide information about what is about to happen to the infant or toddler. With typical infants and toddlers, caregivers often tell them what is about to happen. For example, at mealtime adults may say, "It's time to eat." Children begin to learn to associate specific environmental events with spoken communication. With infants having sensory or other impairments, however, it is important to associate the activity with a specific object. For example, consistently allowing a child to feel a bottle prior to feeding or a diaper prior to changing in addition to talking about the event will assist the child in learning basic communication skills. Touch cues, another good technique, are often used in conjunction with object cues. For example, saying "Hi" may be paired with lightly rubbing the child's hand or a gentle tug on the hand may be paired with the word "up." The same touch cues should be used by caregivers, parents and others who interact with the child. Examples of additional object cues and touch cues may be obtained by consulting Rowland and Stremel-Campbell (1987).

Adaptations of the Environment. Another crucial environmental adaptation for infants and toddlers with physical handicaps such as cerebral palsy has to do with correct positioning and handling techniques. Appropriate ways of lifting children and carrying them ensure the safety and comfort of both child and caregiver. An occupational or physical therapist should be consulted on the appropriate techniques for each child. For individual children, a therapist can also suggest positioning techniques that inhibit abnormal reflex patterns and facilitate postural tone. For example, some children may be better able to deal with their environment in a side-lying position.

Proper seating equipment can facilitate more appropriate body movements for children with physical disabilities. Adaptive seating equipment, like corner chairs, is commercially available. A less expensive alternative for adapted seating equip-

ment is the construction of double-walled cardboard inserts placed in car seats or other types of chairs. Horn, Millen, Cavanaugh and Komisar (1987) have provided an excellent step-by-step guide for the construction of cardboard chair inserts for young children with special seating needs. Seating and other adapted equipment and materials should be constructed individually in consultation with a physical or occupational therapist.

Making toys accessible to infants and toddlers with special needs is extremely important. Schaeffler (1988) has offered excellent recommendations in this area. First, toys may need to be stabilized for children having uncontrolled or limited hand movements. This can be accomplished by clamping a toy to a table or using Velcro to attach toys to surfaces. The use of suction cups may be a good alternative. Cardboard boxes used as boundaries make toys' retrieval easier. An individual child's ability to grasp and feel toys can be facilitated by using Velcro to strap the object to the infant's hand or simply "enlarging" the item by wrapping it in tape.

Another problem for many infants and toddlers with handicaps is their inability to gain experience in cause-and-effect relationships. Important knowledge about the environment is constructed when children are able to interact with objects and learn that "If I do this, then that happens." An infant learns that vigorous kicking in the bed will cause an attached mobile to move. Children with limited motor ability often miss such opportunities to experiment with objects. A useful strategy in fostering an understanding of cause-and-effect relationships is the use of mercury switches designed to activate a toy or device when the switch is held in an upright position, and then to turn it off when held sideways or in a downward position. For example, children could use a mercury switch to light a toy or turn taped music on or off. These switches can be attached to the hand or to the head. Mercury switches are both inexpensive and rather easily constructed. The reader is referred to Parette, Strother and Hourcade (1986) for additional information on their construction and use.

The environment must also be considered from a health and safety perspective. Health and safety precautions appropriate for all children should be rigorously enforced in integrated infant care and education settings, such as hand-washing after diapering and requiring immunization documentation. Infants and toddlers with handicapping conditions may have special health needs. For example, staff members will need to know how to use and properly maintain medical devices such as gastrointestinal tubes and how to respond when a seizure occurs. While such health and medical needs may initially seem frightening, staff should know that with proper training these needs can, for the most part, be integrated into the daily routine with minimal disruption. Keep in mind that parents, with little or no formal medical training, are often able to manage these needs at home. Many children with pediatric human immunodeficiency virus (HIV) infection can be accepted into child care settings. The Task Force on Pediatric Acquired Immunodeficiency Syndrome (1988) has developed guidelines for admission standards and special guidelines in managing the health environment.

An important aspect of the total environment is the consideration of families of infants and toddlers without handicaps whose children are enrolled in integrated settings. They often have questions and concerns. Anticipating and addressing these concerns will do much to gain their support and involvement. One effective strategy is to get parents of infants and toddlers with handicaps to volunteer to plan and conduct family-focused meetings where the reasons for integration are discussed from a parent's perspective. Parents of children without handicaps should also be

made aware of the advantages of an anti-bias curriculum that encourages young children to develop positive attitudes toward persons with handicaps. Real-world concerns can be voiced and discussed on a parent-to-parent basis. Such meetings will also present opportunities for the formation of friendships between families, allowing for additional community-based integrated experiences.

Conclusion

The implementation of P.L. 99-457, Part H, is serving as a springboard to the development and improvement of services for infants and toddlers with known or suspected handicaps and their families. An indicator of quality services is the availability of opportunities for these babies and their families to participate in settings in which infants and toddlers without handicaps would participate. Existing child and family care programs, with appropriate staff training and support, can play an important role in meeting both the child care needs of the family and the special intervention needs of the baby. Such services will positively affect the future of both the children and their families. The infants and toddlers should benefit from the models afforded by their nonhandicapped peers at the most crucial time of their development and learning, without the stereotypes associated with special, segregated programs. Families of these children will benefit from the opportunity to become better integrated into the community by using existing child care services. They will also learn early in their child's life that one indicator of quality services is that they are integrated; thus, they are becoming better informed consumers and advocates. Children without handicaps and their families also benefit greatly from opportunities to appreciate and respect differences.

The development and implementation of statewide plans for the provision of services for infants and toddlers with handicaps and their families mandated by P.L. 99-457 offer unique opportunities to blend child care, education and intervention into one comprehensive system to meet the total needs of all infants, toddlers and their families. Two existing models of blended services serve to remind us that quality integrated programming for infants and toddlers is possible (Karnes & Stayton, 1988). The Early Childhood Day Care Model Project is a program of the Region XIX Education Service Center in El Paso, Texas. The primary purpose of this model is to integrate infants and toddlers with handicaps into regular day care settings. The Family Day Care Project in Ann Arbor, Michigan, is administered by the Child Care Coordinating and Referral Service. The focus of this model is to train family day care providers to care for children with special needs.

A moral consensus must be realized that quality, integrated services for infants and toddlers and their families should be available in each state. Building this consensus will require the combined efforts of early childhood educators, child care providers and families of young children. As Smith and Strain (1988) suggested:

> ECSE professionals need to join ranks with other child care advocacy groups in an effort to obtain federal and state legislation that would make available high quality early childhood programming for all children. These universal services should be individually determined, developmentally integrated, and offer a wide variety of specialized services where needed. (p. 42)

Continued on p. 48

References

Anastasiow, N. (1988). Should parent education be mandatory? *Topics in Early Childhood Special Education, 8*, 60-72.

Association for Childhood Education International. E.E. Gotts. (1988). Position Paper. The right to quality child care. *Childhood Education, 64*, 268-275.

Berk, J.J., & Berk, M.L. (1982). A survey of day care centers and their services for handicapped children. *Child Care Quarterly, 11*, 211-214.

Bricker, D. (1988). Commentary: The future of early childhood/special education. *Journal of the Division for Early Childhood, 12*, 276-278.

Fewell, R.R., & Kaminski, R. (1988). Play skills development and instruction for young children with handicaps. In S.L. Odom & M.B. Karnes (Eds.), *Early intervention for infants and children with handicaps* (pp. 145-158). Baltimore, MD: Paul H. Brookes.

Galloway, C., & Chandler, P. (1978). The marriage of special and early education services. In M.J. Guralnick (Ed.), *Early intervention and the integration of handicapped and nonhandicapped children* (pp. 261-287). Baltimore, MD: University Park Press.

Garwood, S.G., Fewell, R.R., & Neisworth, J.T. (1988). Public Law 94-142: You can get there from here! *Topics in Early Childhood Special Education, 8*, 1-11.

Graham, M.S., & Scott, K.G. (1988). The impact of definitions of high risk on services to infants and toddlers. *Topics in Early Childhood Special Education, 8*, 23-38.

Hanline, M.F., & Hanson, M.J. (1989). Integration considerations for infants and toddlers with multiple disabilities. *The Journal of the Association for Persons with Severe Handicaps, 14*(3), 178-183.

Hignett, W.F. (1988). Infant/toddler day care, yes; But we'd better make it good. *Young Children, 44*(1), 32-33.

Honig, A.S. (1985). High quality infant/toddler care: Issues and dilemmas. *Young Children, 41*(1), 77-88.

Horn, E., Millen, C.E., Cavanaugh, C.L., & Komisar, S. (1987). Chair inserts for preschoolers. *Teaching Exceptional Children, 20*(1), 19-22.

Howard, J. (1989). An approach to early intervention: Birth to 3 years. *Infants and Young Children, 1*(3), 77-88.

Karnes, M.D., & Stayton, V.D. (1988). Model programs for infants and toddlers with handicaps. In J.B. Jordan, J.J. Gallagher, P.L. Hutinger, & M.B. Karnes (Eds.), *Early childhood special education: Birth to three* (pp. 67-108). Reston, VA: Council for Exceptional Children, Division for Early Childhood.

Klein, N., & Sheehan, R. (1987). Staff development: A key issue in meeting the needs of young handicapped children in day care settings. *Topics in Early Childhood Special Education, 7*, 13-27.

Kontos, S. (1988). Family day care as an integrated early intervention setting. *Topics in Early Childhood Special Education, 8*, 1-14.

Mitchell, A. (1989). Old baggage, new visions: Shaping policy for early childhood programs. *Phi Delta Kappan, 20*, 665-672.

Moore, J.A., & McLaughlin, S.F. (1988). Medical costs associated with children with disabilities or chronic illness. *Topics in Early Childhood Special Education, 8*, 98-105.

Odom, S.L., & Warren, S.F. (1988). Early childhood special education in the year 2000. *Journal of the Division for Early Childhood, 12*, 263-273.

Parette, H.P., Jr., Strother, P.O., & Hourcade, J.J. (1986). Microswitches and adaptive equipment for severely impaired students. *Teaching Exceptional Children, 19*(1), 15-19.

Rikhye, C.H., Gothelf, C.R., & Appell, M.W. (1989). A classroom environment checklist for students with dual sensory impairments. *Teaching Exceptional Children, 22*(1), 44-46.

Rowland, C., & Stremel-Campbell, K. (1987). Share and share alike: Conventional gestures to emergent language for learners with sensory impairments. In L. Goetz, D. Guess, & K. Stremel-Campbell (Eds.), *Innovative program design for individuals with dual sensory impairments* (pp. 49-75). Baltimore, MD: Paul H. Brookes.

Schaeffler, C. (1988). Making toys accessible for children with cerebral palsy. *Teaching Exceptional Children, 20*(3), 26-28.

Sells, C.J., & Paeth, S. (1987). Health and safety in day care. *Topics in Early Childhood Special Education, 2*, 61-72.

Smith, B.G., & Strain, P.S. (1988). Early childhood special education in the next decade: Implementing and expanding P.L. 99-457. *Topics in Early Childhood Special Education, 8*, 37-47.

Task Force on Pediatric AIDS. (1988). Pediatric guidelines for infection control of Human Immunodeficiency Virus (Acquired Immunodeficiency Virus) in hospitals, medical offices, schools and other settings. *Pediatrics, 82*, 801-807.

Vincent, L.J. (1988). Changing economic and social influences on family involvement. *Topics in Early Childhood Special Education, 8*, 48-59.

Widerstrom, A.H. (1986). Educating young handicapped children: What can early childhood education contribute? *Childhood Education, 63*, 78-83.

Continued on p. 50

APPENDIX

Integrated Environmental Checklist

	Yes or No	Comments
1. Would you want your infant to spend the day in this environment?		
2. Is the environment cheerful and pleasant?		
3. Are the equipment, decor, furniture and wall displays age-appropriate?		
4. Is the environment safe?		
5. Are care and play areas organized, neat, labeled and accessible?		
6. Is the environment organized to allow for privacy during change of clothing, diapering and toileting?		
7. Is there an appropriate level of sensory stimulation in the environment?		
8. Is the furniture the correct size for each child?		
9. Does each child with special needs have and use appropriate adaptive equipment or corrective aids?		
10. Is each child's equipment in good working order?		
11. Are lighting levels sufficient, and are light sources individualized and adjustable?		
12. Does the environment have adequate sound-dampening and sound-enhancing features?		
13. Does the organization of the environment promote orientation and independent mobility?		
14. Does the organization of the environment promote anticipation of scheduled events?		
15. Are each child's belongings tactually or visually identified?		
16. Is the daily schedule posted?		
17. Are individual children's goals, objectives, conditions and criteria posted?		
18. Is the means of recording child progress in view?		
19. Are photographs and descriptions of prescribed positions for students who have physical impairments posted?		
20. Would you still want your infant to spend the day in this environment?		

Note. Adapted with permission of authors from "A Classroom Environment Checklist for Students with Dual Sensory Impairments" by C.H. Rikhye, C.R. Gothelf & M.W. Appell, 1989, *Teaching Exceptional Children*, 22(1), 44-46.

Section II

Issues and Dilemmas Confronting Infants, Toddlers and Families

Chapter 5

Health Issues in a Changing Society

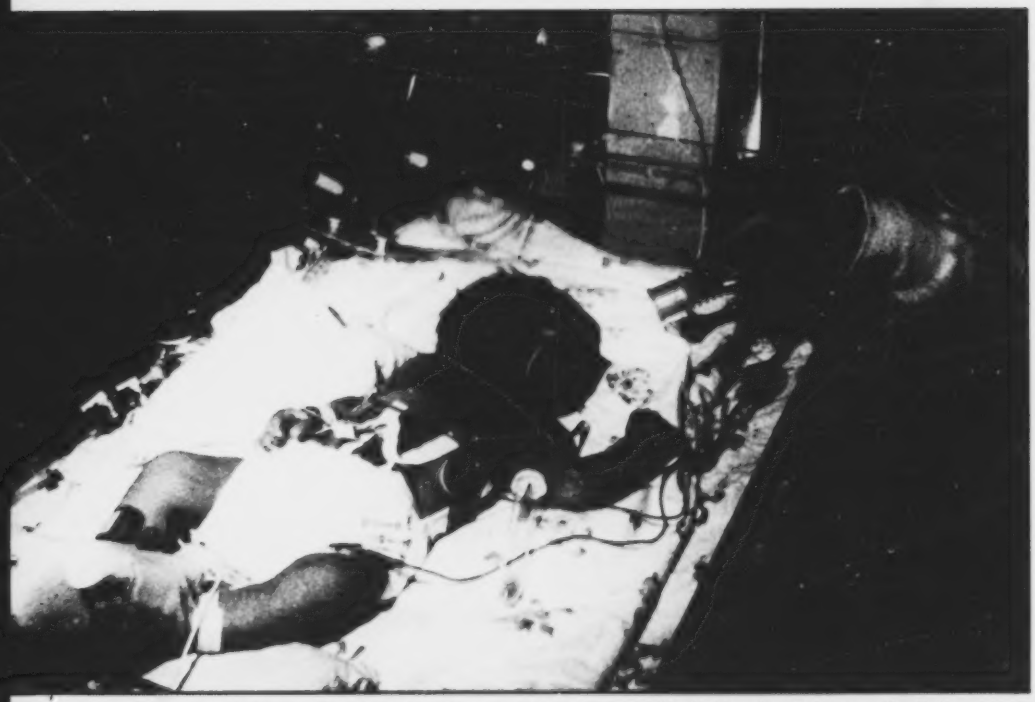
Veronica D. Feeg
George Mason University

Although tremendous advances have been made in pediatric medical care in the last decade, the status of health and safety of children has not comparably improved. Technology can support newborns who would not have survived at birth 10 years ago through the infancy period; but these small and fragile babies, destined for a rocky habilitation, are often discharged into communities ill-prepared to deal with less than competent children. It is difficult to understand why the United States is still ranked 18th among industrialized nations in infant mortality and compares poorly to most Western nations in protecting and immunizing well children and caring for sick ones.

The current status of American children's health is not the positive indicator that should be expected from a nation whose technological and economic status is second to none. The data on the health of our children are a shadowy forecast of a generation yet to grow up in American society. For example, the National Association of Children's Hospitals and Related Institutions (NACHRI) reports that: a) approximately 40 percent of children age 1 to 4 were not immunized against measles, mumps, rubella or polio in 1984 (in fact, immunization levels among preschool children dropped 10 percent for DPT and 20 percent for polio from 1970 to 1984); b) nearly 40,000 of the 3.6 million children born in 1984 died before their first birthday; c) approximately 1 in 5 children has no health insurance at all—public or private (NACHRI Report, 1989).

Many families are in turmoil today (Great American Family Tour, 1988), facing dilemmas that were the exception in previous decades, and society lacks the organizing framework to assist the family—a basic unit of health care—through difficult or troubling times (Barnard, 1989). As a society, we continue to place importance on the family's care and socialization of family members. The increasing complexity of society, however, has changed the conditions in which the family must carry out its basic functions. Societal stressors that affect the family unit include: a) the financial necessity in many two-parent families for two incomes in order to "make ends meet" (Barnard, 1989); b) the difficult task of providing a stable and loving home environment when many families are single-parent households, economically disadvantaged or fundamentally uneducated; and c) the challenging situation of repetitive teenage parenting, when children are born to parents who are children themselves—and the cycle repeats itself (Ulvedal & Feeg, 1983).

The interrelatedness of factors in health, family and environment forms a conceptual framework for understanding general issues that affect developmental programs and specific early childhood interventions. These factors independently and interdependently contribute to the successful and healthful development of every child.



Gus A. Ostrum. Reprinted with permission from *Pediatric Nursing Forum on the Future: Looking Toward the 21st Century* (1989)

Health and Development

Perhaps the single, most powerful influence on poor health outcomes and developmental difficulties is poverty and its correlates. NACHRI Fact Sheets (1989) reports that in 1985, children under 18 accounted for 38 percent of the poverty population. One-third of all children living below the federal poverty level have no health insurance. They account for 39 percent of all uninsured children. What accompanies lack of health insurance is subsequent lack of health care services, real and preventive, except in conditions of catastrophic or acute emergencies, when the potential for recovery or habilitation is minimal and the cost of treatment or follow-up exorbitant.

Medicaid served 21.8 million low income people in 1985, of whom 44.7 percent were children in low income families. Medical indigency—the inability of people near or below the poverty line to pay medical bills—is an increasing problem affecting the quality and quantity of health care services in general and prenatal care services specifically.

Second only to socioeconomic status, the prenatal care a woman receives or fails to receive is the most important determinant of birth outcome, including low birthweight, stillbirth or critical illness in the first year of life. In 1978, 21.8 percent of white mothers, 39.8 percent of black mothers, 43.7 percent of Native American mothers and 43 percent of Hispanic mothers received no prenatal care during the first trimester of pregnancy. Since 1978 there has been virtually no reduction in the percentage of pregnant women receiving late or no prenatal care. Poor women in the

United States are three times more likely than their non-poor counterparts to receive late or no prenatal care. Women who receive late or no prenatal care are three to six times more likely to bear low birthweight babies (NACHRI Fact Sheets, 1989).

Newborn Health Issues

Health outcomes in the newborn period are critically dependent on the health of the mother, which is statistically related to the economic status, educational experience and general stability of her family of origin or her new family (relationship with her significant other). Three major problems today of critical proportion in the newborn period, in terms of statistics or poor prognoses, include: a) low birthweight, b) HIV and other congenitally transmitted infections, and c) the growing number of drug-addicted neonates.

The low birthweight rate for a population is defined as the number of infants weighing less than 2,500 grams (5.5 lbs) at birth per 100 live births. In 1978, the proportion for low birthweight was 7.1 percent of all births: 5.9 percent for whites, 6.7 percent for Native Americans and 12.9 percent for blacks, while rates for many other developed countries are 5 percent and less. The young age of the mother is a strong predictor of low birthweight. In 1984, over 247,000 babies (6.7 percent of all births) were born too small and/or too early (NACHRI Fact Sheets, 1989).

Low birthweight data predict physical health-related outcomes for the newborn throughout the infancy period. Premature and small-for-gestational age neonates are three times more likely to develop a permanent impairment, 40 times more likely to die in the first month of life and 20 times more likely to die in the first year of life. Factors known to be associated with low birthweight include: a) unintended pregnancy, b) previous low birthweight or a history of other reproductive complications, c) poor health habits before and during pregnancy (particularly smoking, drug and alcohol use), d) low maternal weight gain, e) medical conditions including obstetrical or chronic diseases and f) no or late quality prenatal care.

A decade ago, the prognosis for babies born under 2,500 grams was poor. Today, more than half (57 percent) of infants born weighing less than 1.6 lbs at birth and 72 percent of those weighing 1.6 to 2.2 lbs at birth are discharged alive (NACHRI Fact Sheets, 1989). Of the low birthweight infants who survive beyond the infancy period, many are destined to a lifelong struggle of technology dependency or chronic care needs. Aside from ethical questions that arise as a result of technological interventions in infancy, the problems associated with managing a growing number of children with complex health and developmental needs challenge a multitude of professionals who care for them. As David Sexton pointed out in the previous chapter, these children need the benefits of multidisciplinary professionals who plan their services with an understanding of the interrelatedness of their conditions.

In addition to the societal antecedents related to poverty common to low birthweight and poor health conditions in infants, the recent epidemic of AIDS has ravaged the most vulnerable population—infants born to HIV-positive mothers. The sources of transmission of the HIV virus include sexual activity (usually homosexual but also heterosexual), blood transfusion, contamination via intravenous drug use and placental transfer from mother to child in the fetal period. From a variety of combinations of interpersonal transmissions of the disease, more and more women, particularly in impoverished environments, are becoming infected with the AIDS virus. Infants born to mothers who carry the AIDS virus are susceptible to acquiring the virus and likely to be stricken by the disease.

The number of cases of AIDS in children's hospitals has doubled each year since 1983, and the 584 cases reported in September 1987 by the Centers for Disease Control are probably understated; 19 children's hospitals alone reported 648 cases in a recent NACHRI study (NACHRI Fact Sheets, 1989). Currently, it is estimated that 3,000 children annually are born with HIV infections. By 1991, some predictions estimate, 10,000 cases of pediatric AIDS are likely (Oleske, Connor & Boland, 1988).

The profound ramifications of providing services to a growing number of abandoned, orphaned, frequently ill or potentially terminal children, particularly with the stigma that these children carry in their own communities, have only recently been addressed in the literature and health policy discussions. While it is essential that the family of the HIV-infected child play an integral role in the care of the child, it is important to note that parents may very likely be HIV positive as well, with accompanying complications that may render them unable to care for their child adequately (Williams, 1989). The child care professional, again, needs to sustain an understanding of the interrelatedness of physical illness, family and environment in order to provide services that promote development.

Along with congenitally acquired infections, such as AIDS, the problems associated with newborns in hospitals today with congenitally acquired drug addictions are staggering. The effects of maternal narcotic substance abuse such as heroin on the neonate include severe problems related to withdrawal and clinical conditions: central nervous system hyperirritability, respiratory distress, tremors, fever, uncoordinated reflexes such as sucking and swallowing, dehydration and possible electrolyte imbalance (Merker, Higgins & Kinnard, 1985). Perinatal addiction often results from mothers who are multi-drug users (Leifer, Goldman & Finnegan, 1983), and the more recent reports in the press of increasing cocaine use among women suggest that the 10-year-old estimate of 5,000 narcotic-exposed infants born yearly (Werblum, Cullison & Erickson, 1979) is sadly understated.

Once again, the source of the problems of drug abuse cannot be rooted in a single or unidimensional cause. The role of the family and the impact of an impoverished environment contribute to the complex problem of drug abuse that appears pervasive. Without a doubt, maternal drug abuse and the factors associated with it affect the newborn's physical health and potential development.

Infant Health Issues

The newborn is most vulnerable to crisis or critical illness during the neonatal period, sometimes considered chronologically to 7 days or up until hospital discharge. In the post-neonatal period, infants are inextricably dependent for physical survival on their parents or caregivers. The importance of the parent-infant relationship to the emotional and physical well-being of the infant has received considerable attention in the developmental literature, which validates the need to consider health and family simultaneously in planning services that optimize the child's development.

The health-promoting behaviors of the infant's caregivers, which include providing adequate nutrition, assuring safety and caring for episodic illnesses in the first year of life, are essential bases for the developing child to accomplish the predictable developmental milestones and grow to a healthy, competent, curious and interdependent toddler in the year to follow. The parents of the infant need cognitive competence and adequate knowledge of basic health-promoting activities; simple, common-sense care such as good hygiene and infant feeding are sometimes beyond the capabilities of some young or troubled families.

Parents and caregivers of the infant need to recognize real and potential safety hazards in the child's world and know what to do to child-proof the creeping-crawling infant's physical space. Falls from changing tables, choking accidents from small objects in throats and car accidents contribute vastly to the untimely deaths in infancy. To combat the grim statistics related to infant traffic fatalities, the American Academy of Pediatrics has influenced many state departments of transportation and state legislatures to mandate the use of infant car seats.

Other than during the neonatal first weeks of life, sudden infant death syndrome (SIDS) is the single leading cause of infant death. The inexplicable sudden death of an infant is contrary to what all parents anticipate in their otherwise healthy infant (Chan, 1987). Approximately 2 to 3 per 1,000 live births per year are attributed to these unexplained "crib deaths" of infants between 7 and 365 days old (Peterson, Chinn & Fisher, 1980). The causes, associations and antecedents of SIDS remain somewhat an enigma to health professionals; but children who might appear to be at risk for apnea (cessation of breathing) are being identified from a variety of physical health conditions, including respiratory problems in the newborn period, and treated with close monitoring. Whether this intervention prevents SIDS remains questionable.

Finally, health issues of the infancy period must include conditions considered "normal" childhood episodic illnesses. Many early childhood diseases once considered inevitable can be virtually eliminated by immunization efforts. Some of these illnesses, including measles, mumps, pertussis (whooping cough) and several others are not usually considered life-threatening but can cause death or disability in certain circumstances. Additionally, rubella (German measles) has taken its toll on other family members or exposed contacts; when the person exposed is a pregnant female, the rubella virus produces developmental after-effects in the future newborn.

Even childhood "chicken pox" (Varicella zoster) can produce problems for the affected child, adults or immunosuppressed individuals exposed to the child. Due to this threat, there is current consideration of immunizing children against the virus. The child's first year of life is typically scheduled for routine immunizations for various illnesses. Unfortunately, the number of children immunized by public programs has dropped by 20 percent or more for each of the past 4 years while the demand for programs has increased. Among nonwhite children ages 1 to 4 living in central cities in 1982, 66 percent were not fully immunized against polio (at one time a devastating epidemic) and DPT—diptheria, pertussis, tetanus (NACHRI Report, 1989).

Toddler Health Issues

The second year of life for the child is filled with new motoric skills and independent cognitive experiences. The just-walking, just-talking toddler can wreak havoc in his or her environment, challenging parents and child caregivers to their limits. Potential for harm is ever-present; physical safety is a paramount concern beyond the love, support and attention needed from parents and caregivers.

The physical environment for a toddler can be extremely dangerous. Accidents still account for the highest cause of death during this period; aside from car seat safety, the safety of the physical space must be consciously considered by all persons entrusted with child care. Children in this age group frequently fall victim to poison-related accidents due to their natural curiosity about materials, oral-types of behavior and caregivers' oversight of the potential hazards. These dangerous ingestions—most likely to occur in the kitchen, bathroom, bedroom or work area—are usually

Veronica D. Feeg. Reprinted with permission from *Pediatric Nursing Forum on the Future: Looking Toward the 21st Century* (1989)

discovered by the parent or caregiver after finding an empty or open container or a half-eaten leaf or other substance (Edelman & Mandel, 1986).

In addition to its active position on car seats for small children, the American Academy of Pediatrics has advocated strongly for bicycle helmet use by directing public attention to the increasing problem of preventable head injuries. The structure of the infant's head before 18 months and the gradual closure of cranial sutures (fontanels) allow the infant to test increasing motor competencies and endure minor falls or bruises in the process. When the back fontanel closes, however, the toddler's head has little potential for sustaining bicycle falls or harsh head injuries. Helmet safety is important for small children riding with parents and should be considered for all children (and adults) who ride bicycles with traffic.

General, occasional illnesses in the first few years of life are common for all children. Usually a cold, "upset tummy," diarrhea, strep throat or ear infection may interfere with a family's routine and influence an infant or toddler's behavior; but these sicknesses are typically treatable, short in duration and relatively nonsignificant. Unfortunately, without health care, without competent adult identification of the problem and early medical or diet therapies, without recognition of potential long-term consequences, many children may be found to have serious illnesses or future developmental difficulties. For example, a continuous cold may not be a cold at all; the child may have a serious unrecognized allergy that can increase in severity and affect behavior. An "upset tummy" and diarrhea can rapidly result in serious dehydration for an infant or toddler. An undertreated strep infection can produce significant lifelong health problems; an untreated or chronic ear infection, sometimes invisible to the parent, can damage the child's auditory mechanisms, interfering with

hearing and possibly later with language learning and production.

Child care professionals need to be aware that health care services for episodic illnesses are not available for many children today. There are 12 million children with no health insurance at all (Hardin, 1988), whose families are frequently on limited incomes and must choose carefully whether or not to seek medical attention. These relatively minor sicknesses, unfortunately, must become major problems in order for the parent to decide whether a visit to the doctor takes priority over paying the rent.

Caregiver guidance about preventable health and safety issues could provide the toddler's family with information and attention about normal child development. Health teaching related to nutrition and eating, discipline, growth, hygiene, safety and development of the toddler establishes an information base for parents and families to nurture their children.

In many of today's families, however, access to health services and the ability and motivation to use information related to health and safety are lacking. The influence of the environment, life experiences or lack of education may hamper some families in assuring a safe and healthy home, not to mention a stable, stimulating or affection-filled home. Child care professionals need to instill in the family, through education and counseling in their services, an appreciation of the importance of the parent-child relationship and understanding of the environmental influences on these families. Also, they should continue to advocate for social policies that address the disparity in health and illness statistics between poor and nonpoor, white and nonwhite children.

Need for Improved Health Services

Although the technology pioneers continue to advance the state of medical science, the state of child health service delivery remains poor. Many American children and pregnant mothers receive less than adequate care during critical periods: most states' Medicaid regulations allow fewer well-child visits than recommended by the American Academy of Pediatrics; in 1984, 1 birth in 20 was to a mother receiving either late prenatal care or none at all (NACHRI Fact Sheets, 1989).

Much of our health service is illness focused, medically based and individually delivered. The "identified" patient/child may receive attention and therapy related to a "chief complaint," but the lack of integration of the family into the treatment plan and further lack of understanding of environmental circumstances limit true results. Parents and caregivers must have valid information and training to help in the prevention of potential problems or complications related to current conditions. This is imperative. Narrowly delivered health services and nearsighted health policies fail to improve health or development for the many children who need them. Again, the readers are encouraged to review the programmatic suggestions offered earlier by Sexton relating to medical management and environmental adaptations for young "atypically developed" infants and toddlers and their families.

The family is the basic system in which health behaviors are learned, selected, obtained and provided. Child care professionals must support the family as a unit of care when at all possible (Gill, 1987), recognizing the health of the child as a dependent condition of the family unit. Using a family-centered approach in identifying problems and formulating interventions takes into account the dynamics of the child within the family unit. Family-centered care strengthens the importance of the child-parent interactions and forms the foundation for emotional well-being upon which to build healthy child development.

PRACTICES THAT PROMOTE EMOTIONAL WELL-BEING

Recognizing the family as a unit of care, child care professionals may approach infant and toddler care equipped to serve parents and child equally well. Supporting the parent-child and early maternal-child attachment activities strengthens the mutual feelings of success, the motivation to continue engaging in these activities and the emotional well-being of parent and child.

Parent-Child Interaction

As described by Honig in chapter 1, in the earliest days of development, touch and acquaintance activities between parent and neonate can initiate mutual feelings of warmth. Even the growth and development of preterm newborns, in limited and monitored circumstances, have been facilitated by massage or tactile/kinesthetic stimulation (Field, Scafidi & Schanberg, 1987). Activities in feeding, bathing, dressing and general caretaking stimulate face-to-face engaging, parent-child communication, mutual learning and recognizing cues, and feelings of gratification between caregiver and child. Such behaviors can be fostered by assisting parents while performing these activities to realize the potential of their actions (Barnard, 1978).

These parent-child practices should be supported—not taken over—by child care professionals. In the event of acute, chronic or catastrophic illness, health care professionals must strive to preserve and maintain the parent-child relationship and family participation in care.

The Association for the Care of Children's Health (ACCH), with its position statement on "Involvement of Parents and Families in Health Care Settings," reaffirmed its stand on care of children and their families with the central concepts of: a) maintenance of child-family relationships, b) establishment of a sense of parenting with or without parental presence, c) recognition and respect of individual family coping styles and d) management of family-health care system conflicts (ACCH, 1981).

Principles of Care That Minimize Trauma

Occasional circumstances force infants and children into unpleasant and uncomfortable medical and health treatments. Unfortunately, minimizing the trauma of medical interventions has not kept pace with the technological advances of preserving life; much of what is done to children in these circumstances is painful, upsetting and frightening.

Wong (1989) presents a strong case for *atraumatic care*, reestablishing an orientation of health care and services that sustains a central premise of avoiding trauma: "With knowledge of the stressors imposed on ill children and their families and armed with interventions shown to be safe and effective in eliminating or reducing the stressors, health professionals must direct their attention to providing care that is as atraumatic as possible" (p. 42).

Practices that serve to promote emotional well-being while treating unavoidable illness conditions can be principles for general child care. Wong defines *atraumatic care* as the provision of therapeutic care by personnel through interventions that eliminate or minimize the psychological and physical distress experienced by children and their families. Psychological distress may include anxiety, fear, anger, disappointment, sadness, shame or guilt. Physical distress may range from sleepless-

ness and immobilization to disturbing sensory stimuli, such as pain, temperature extremes, loud noises, bright lights or darkness. The major principles include: a) do no harm (the adage "in the best interest of the child" must be carefully considered), b) maintain the parent-child relationship, c) promote a sense of control (for child—and parents) and d) prevent or minimize bodily injury and pain. "When the illness has passed or the injury has healed, children should be no worse off than before the episode just for having been sick" (Wong, 1989, p. 43).

Conclusion

Ultimately, we must work for improved social and health policies to improve the health and development of children and their families. To improve current health services, policymakers must give their first attention to the impact of poverty on everyone's health. Immunization programs, health insurance coverage and efforts in combating illness or emphasizing accident prevention affect not only the poor, but all children. Resources are drained from the many when expensive technological interventions are necessary for the few. Many incidents causing need for children's catastrophic care are preventable. Each dollar spent on prenatal care saves three dollars of high-tech intensive care cost for low birthweight newborns (Feeg, 1989). Additional monetary and health and social savings can be accomplished by offering family-centered training and educational experiences to enhance healthy development of children.

References

Association for the Care of Children's Health (ACCH). (1981). Position statement on involvement of parents and families in health care settings. *Children's Health Care, 8,* 69-71.

Barnard, K. (1978). *Learning resource manual: Nursing child assessment satellite training (NCAST).* Seattle, WA: University of Washington, School of Nursing, Nursing Child Assessment Project.

Barnard, K. (1989). Family resources: Future support services. In V. Feeg (Ed.), *Pediatric nursing forum on the future: Looking toward the 21st century* (pp. 60-61). Pitman, NJ: Anthony J. Jannetti.

Chan, M. (1987). Sudden infant death syndrome and families at risk. *Pediatric Nursing, 13,* 166-168.

Edelman, C., & Mandel, C. (1986). *Health promotion throughout the lifespan.* St. Louis: C.V. Mosby, Co.

Feeg, V. (1989). New legislative efforts to improve child health and decrease infant mortality. *Pediatric Nursing, 15,* 145-148.

Field, T., Scafidi, F., & Schanberg, S. (1987). Massage of preterm newborns to improve growth and development. *Pediatric Nursing, 13,* 385-387.

Gill, K. (1987). Parent participation with a family health focus: Nurses' attitudes. *Pediatric Nursing, 13,* 94-96.

Great American Family Tour. (1988). *Speak out for families.* Washington, DC: Author.

Hardin, A. (1988). Bringing family issues into the campaign spotlight. *Pediatric Nursing, 14,* 399-400.

Leifer, E., Goldman, J., & Finnegan, L. (1983). Prevalence and implications of multi-drug abuse in a population of methadone-maintained women. *National Institute of Drug Abuse Research Monograph Series, 43,* 322-328.

Merker, L., Higgins, P., & Kinnard, E. (1985). Assessing narcotic addiction in neonates. *Pediatric Nursing, 11,* 177-181.

NACHRI Fact Sheets. (1989). In V. Feeg (Ed.), *Pediatric nursing forum on the future: Looking toward the 21st century* (pp. 4-10). Pitman, NJ: Anthony J. Jannetti.

NACHRI Report. (1989). *Profile of child health in the United States.* Alexandria, VA: National Association of Children's Hospitals and Related Institutions.

Oleske, J., Connor, E., & Boland, M. (1988). A perspective on pediatric AIDS. *Pediatric Annals, 17,* 319-321.

Peterson, D., Chinn, N., & Fisher, L. (1980). Sudden infant death syndrome: Repetitions in families. *The Journal of Pediatrics, 97,* 265-267.

Ulvedal, S., & Feeg, V. (1983). Profile: Pregnant teens who choose childbirth. *American Journal of School Health: Special Research Edition,* 35-39.

Werblum, M., Cullison, S., & Erickson, S. (1979). Narcotic abuse in pregnancy. *The Journal of Family Practice, 9,* 711-716.

Williams, A. (1989). Nursing management of the child with AIDS. *Pediatric Nursing, 15,* 259-261.

Wong, D. (1989). Principles of atraumatic care. In V. Feeg (Ed.), *Pediatric nursing forum on the future: Looking toward the 21st century* (pp. 42-46). Pitman, NJ: Anthony J. Jannetti.

Chapter 6

Infant Day Care

Michael F. Kelley and Elaine Surbeck
Arizona State University

Previous chapters have pointed out the increasing need for quality care responsive to families with infants and toddlers. Indeed, the demand for child care services is far outstripping the country's commitment to provide quality care for its children. It is estimated that the families of 10 million children under the age of 5 require child care. More specifically, 5 million infants and toddlers need provisions for quality care. With four out of five women between the ages of 25 to 54 expected to be working by the turn of the century, the demand for quality child care will continue to rise (Children's Defense Fund, 1989).

A current, pressing issue facing early childhood education is that of day care for infants. Clarke-Stewart (1988) suggests that the fastest growing segment of working mothers to date are those with infants between 3 weeks and 3 months of age. She foresees that soon half the mothers of infants will be working. The need for quality care for infants is great, but controversial. Debates in the research community and the popular press concern the positive and/or negative effects of long-term nonmaternal care of infants (Fox & Fein, 1988; Wingert & Kantrowitz, 1990). Yet, while debates continue, more and more young infants and toddlers are either waiting for quality care or are currently receiving care described as "substandard or nonexistent" (Children's Defense Fund, 1989). Generally, there is no personalization of care for these children.

The purpose of this chapter is to highlight the major issues that surround infant day care. The most common types of care for infants and toddlers are briefly described. Our goal is to identify those settings offering the greatest opportunity for personalization of care with both infants and families. After examining the types of care available, we review current debates about infant day care now demanding considerable research efforts and consumer time. Specifically, key controversial issues in these debates are examined within a developmental framework that may help caregivers understand the uniqueness and importance of their work with infants and families. Finally, some suggested ideas to improve infant day care are listed.

TYPES OF CHILD CARE ARRANGEMENTS

Child care may take a variety of forms and serve a number of functions for families. Some families have only an occasional need for child care and thus will rely on a family member or babysitter or on part-time child care. An estimated 30 percent of employed mothers work part-time (Hofferth, 1989). Other parents have an all-day, every-day need for child care. Roughly 40 percent of children younger than 6 have mothers who work full-time year round (Zill, 1988). As stated previously, an increasing number of these are mothers of infants. Though many parents would like to remain at home with their infants, current employment policies do not provide for

parental leaves of absences or job security guarantees (Children's Defense Fund, 1989). With more and more families headed by single parents, child care becomes a dire necessity; these families *must* seek child care alternatives.

Families may rely on in-home care by a relative (48 percent of children of employed mothers used this type of arrangement in 1985), a nonrelative "nanny" in the child's home (roughly 6 percent of children), family day care homes (approximately 22 percent of children) or center-based child care facilities (roughly 23 percent of children) (Hofferth, 1989). Many of these are expensive alternatives requiring substantial financial commitment. In fact, family day care and center-based care costs for full-time (40 hours/week) care can vary from $40.00 to more than $100.00 per week (Ad Hoc Day Care Coalition, 1985; Hofferth, 1989), a significant proportion of the family budget for some low income families.

Current trends suggest that family day care homes are the main child care arrangement for infants under 3 years, and even more so for infants under 1 year (Eheart & Leavitt, 1989). Infant care in center-based child care facilities, however, is increasing (Hofferth & Phillips, 1987).

For most infants, the best personalization of care is provided within the family structure. With mom, dad or a caring relative at home responding affectionately and regularly to a baby's needs, the infant begins to develop a sense of understanding that the world is predictable and nurturant. Thus, parental or kin-related care of young chidren during the first 3 years of life is the preferred recommendation, provided the adult is motivated toward such care and can afford the economic sacrifices.

The next highest level of personalization of care with infants is probably that of engaging a highly qualified nonrelative "nanny" to provide care within the home of the infant. This option offers continuity and stability of the home atmosphere and more one-to-one interactions between caregiver and baby than out-of-home group care. As suggested in the previous chapters of this book, it is the quality of the caregiving personalized for the infant that contributes to successful development.

Regrettably for many families, the above two options are not possible. They must turn to group care that increases the probability of less personalized care for their baby. Please note that we are well aware that group forms of child care can be of high quality. Our main thesis is relatively straightforward. Whenever the size and composition of the care-dependent group increase or change, the delivery of personalized, dependable, affectionate and individualized ministration is likely to be somewhat compromised. This situation is particularly probable where group size approximates 4 or 5 infants to 1 caregiver and potentially most hazardous when the infants are under the age of 1; it is also greatly influenced by the role perceptions of the caregiver. After examining briefly the two most common forms of out-of-home group care, we will return to this issue, which has fomented considerable debate and disagreement about the effects of intensive out-of-home care for very young infants.

Family Day Care Homes

In a typical family day care home, a provider cares for a group of children within the confines of the provider's own home. Group size will vary, depending on whether the day care home is licensed. In such a licensed home, usually no more than 5 unrelated children may be present at one time. Unfortunately, only an estimated 25 percent of family day care homes are licensed (Ad Hoc Day Care Coalition, 1985). Thus, the group size mentioned above may be vastly exceeded in unlicensed homes. One thing we know about providing quality care for infants and toddlers is the need for low caregiver-to-child ratios. As Sexton noted, a 1:3 ratio is highly desirable.

E. Anne Eddowes

Center-based Child Care

As suggested earlier, center-based care for infants and toddlers is growing. Centers are usually licensed by a state or community agency. But agency monitoring of center-based facilities for quality-related facets of "good" care often ranges from limited to nonexistent. In many instances, group size allowances for centers are based on the square footage of the building or room to be used. To suggest that center-based child care regulations around the country are protecting the youngest children from substandard care may be a misconception. Given the fact that low caregiver-to-child ratios contribute significantly to the quality of the personalized care, we find unfortunately that 10 states allow caregiver-to-infant ratios of 1 to 6. Georgia and North Carolina allow 1 caregiver to provide for 7 infants; South Carolina caregivers may have to provide for as many as 8 infants (Children's Defense Fund, 1989, p. 58). Even when the ratio is limited to 4 infants to 1 caregiver, it is not unusual for center-based programs to double or even triple the number of infants in one room by merely adding additional staff to maintain the ratio limit. The net effect of this practice can only decrease the personalization of care and concomitantly increase the probability of illness, injuries and inappropriate use of such poor practices as bottle propping. In addition, there is increased use of walkers, swings and other developmentally unsuitable corralling mechanisms. Personalized care in settings with large numbers of children is extremely difficult to achieve.

Fully important as the caregiver-to-child ratio is the quality of provider training specific to understanding and working with children under 3.

> Twenty-eight states have such low expectations of family day care providers that they require neither training in child development nor any prior experience. Twenty-eight states require no training before teachers come to work at day care centers. (Children's Defense Fund, 1989, p. 58)

In Arizona, an assistant teacher-caregiver who works with young children in a child care center needs only a high school diploma or its equivalent and the desire to work with children. Recently, Arizona began requiring all child care personnel to be fingerprinted and checked for past law violations.

Other issues relevant to the quality of care provided our youngest children are continuity and stability of care. Unfortunately, many families must move their children in and out of multiple care arrangements in order to meet their daily child care needs (Ad Hoc Day Care Coalition, 1985). This lack of continuity and stability has raised considerable concern among child development professionals for infants' emotional and social development and growth. Specifically, the issues focus on the effects of out-of-home care on very young infants' emotional and social attachments and the potential subsequent effects in preschool and primary school years.

THE DEBATE ABOUT INFANT DAY CARE

During the past 15 years, child development researchers have been examining the emotional and social development of young infants who experienced much out-of-home group care during their first year, comparing them to other children who received out-of-home care beginning some time *after* the infant's first year. Of central concern are the following questions: "Does early out-of-home group care negatively affect the emotional security and attachment behavior of infants?" "Are there any negative long-term effects of these arrangements?"

Initially, the research reviews indicated that early out-of-home care did not negatively affect young infants' intellectual or emotional development but appeared to have some potential influence on later social development. That is, children reared in day care appeared to be slightly more aggressive and less responsive and compliant with adults (Belsky & Steinberg, 1978). More recently, research and alternative interpretations of previous studies have led to a new concern. Particularly distressing to many has been the argument by Jay Belsky (1988) that infants placed in nonmaternal care for more than 20 hours per week during their first year of life are at-risk for later difficulties, which may include the "development of insecure-avoidant attachments in infancy and heightened aggressiveness and noncompliance during the preschool and early school-age years" (Belsky, 1988, p. 235). Belsky's reports and interpretations were so disconcerting that *Time, Newsweek* and other popular magazines published accounts of the bad news about infant day care (Wallis, 1987; Wingert & Kantrowitz, 1990; Zinmeister, 1988). Such reports alarmed many parents with children in child care settings. Additionally, this information angered child care providers, policymakers and even some of Belsky's professional colleagues. It must be noted here that the at-risk patterns reported by Belsky do not regularly appear in young children who begin out-of-home care experiences *after* the first 12 to 15 months of age. Thus, the bulk of the discussion in this chapter will focus on infant child care concerns during the first year of a baby's life.

Others reviewed Belsky's research and interpretations and drew different conclusions (Fox & Fein, 1988). Generally, the panel of researchers who reviewed Belsky's findings suggested that he overstated the magnitude of the problem of those found to be insecurely attached; they questioned Belsky's views about the nature of attachment and whether the use of the Strange Situation Test is too narrow in scope. (This is a laboratory procedure purporting to measure the quality of the mother-infant attachment through brief sequential separation and reunion episodes.) In fact, several researchers suggested that insecure or avoidant behavior shown by some infants could be interpreted as a display of social competence in learning how to adjust to different situations. Hence, infant child care could prove to elicit positive social and emotional effects. Finally, the panel suggested a number of contributing factors that could influence interpretation of responses to the Strange Situation Test. These include, among others: a) different background experiences or personal histories of the infants; b) family characteristics, such as the health of the parent-child relationship, parental emotional accessibility and behavioral sensitivity and parental attitudes toward child care; c) the quality of the center-based care.

In sum, most researchers after reviewing the work of Belsky and his colleagues concluded that the jury remains "out" and that more data and information are needed before red flags are raised against infant out-of-home care. Furthermore, it is argued that infant care is here to stay and that we need to begin generating ways of improving what children experience during that care.

What seems to be missing in all this narrow, empirically driven infant day care research with its "adoration of hard data" is a rich, naturalistic perspective about the development of individual babies. Zimiles argues rather forcefully that:

> . . . absent in most discussions of the effects of nonmaternal care are the voices of child development specialists, clinicians and researchers, whose work entails prolonged and intense naturalistic observation of young children—rather than the analysis of data obtained from young children under brief, controlled experimental conditions. . . . Knowledge of young

children that stems from sustained whole-child observations that yield integrated and comprehensive views of the psychological organization of young children is most likely to provide valid information regarding their principal psychological needs and developmental tasks, the kinds of experiences that produce stress and their modes of responding to it, and the long term consequences of stressful experiences. (Zimiles, 1989, pp. 20-21)

In short, Zimiles questions the validity of comparatively brief, systematic assessments of infants that are being used to study the effects of early nonmaternal care.

Infant care considered in a developmental perspective supports the suggestions of Zimiles (1989) and Sroufe (1988), who also argue for detailed longitudinal studies that examine parental feelings and attitudes and their interaction with the ongoing process of parent-child interaction. Sroufe asks us to consider the issue of child care within the context of normal developmental processes. He points out, as does Honig in the first chapter of this book, that "secure attachment is not something inherent in the infant; it is a product of the infant-caregiver interactive history" (p. 285). Thus, the normally developed, securely attached infant comes to expect responsive care from an emotionally available care provider. Disruptions in the availability and responsiveness of care may make an impact on the infant's confidence in getting what is requested. Additionally, lack of caregiver availability and responsiveness may result "in lost opportunities for ongoing tuning of the emerging infant-caregiver interactive system" (Sroufe, 1988, p. 286). When infants are in extended out-of-home care arrangements, parents miss vital opportunities to participate in the interactive process.

Although this debate over the impact of out-of-home infant care will continue for years, the fact remains that infant out-of-home care is growing in usage. While one may argue that family child care homes are preferable to center-based infant care programs due to the home-like arrangements, recent research of the kind envisioned by Zimiles and Sroufe raises serious questions concerning children's experiences in these settings.

Specifically, in a study examining intended and observed caregiving practices in family child care settings, Eheart and Leavitt (1989) interviewed 31 family child care providers, asking the providers to characterize their daily caregiving responsibilities and activities. Subsequently, six of the providers were extensively observed over a 10-month period to determine whether intended activities and responsibilities were actually occurring. The results were not favorable.

This study suggests that the world of family day care for some children may be one that is void of toys, where commands and demands are more prevalent than questions and comments, where negative affect is commonplace, where children repeatedly experience favoritism, and where the caregiver is emotionally uninvolved with the children. (p. 159)

Whereas the care providers described scenarios of happy children involved in play with emotionally responsive adults, the researchers observed quite different realities. Rare were the behaviors that supported optimal development in children, behaviors such as smiling, talking and affectionate playing described by Honig, Castle and Balaban in earlier chapters.

Much of this lack of responsive care appeared to be related to group composition. Eheart and Leavitt (1989) identify three facets comprising group composition: *group size*, *group continuity*, and the *relationship* of the children to the care provider. As implied earlier, the larger the group size, the greater the competing demands among

children, which greatly diminish the provider's ability to help young children learn to trust and love. Lack of group continuity negatively influences the quality of caregiving by disrupting the stability of care for the children. Over a 10-month period, Eheart and Leavitt reported that in one home 21 children were observed more than once. With different children coming and going on a part-time or full-time basis, one wonders how a caregiver can be continously responsive in a discontinuous arrangement.

Finally, since the children in the majority of family child care homes are not related to the care provider, they do not necessarily receive the emotional "mothering-like" support so important for optimal development. There appears to be, however, some evidence that parents and caregivers associated with family child care homes have stronger interpersonal ties than in center-based settings (Powell, 1989). Positive interpersonal ties, coupled with more time and effort spent talking about particular infants, can help both parents and caregivers fine-tune the role perceptions and relationships that each must develop to effectively personalize the care. While the caregiver will never replace the mother, the behaviors evinced by the caregiver can certainly approximate those of a loving, caring relative.

Thus, we have come full circle to our earlier thesis regarding the relationship between level of personalization of care and group composition. Finally, this chapter addresses a few strategies that may prove helpful in crafting better quality infant care.

WHAT DOES THE FUTURE HOLD?

In an attempt to avoid traversing too far into policy issues that Eleanor Szanton will highlight in the final chapter, we will limit discussion to items specifically related to infant child care.

❑ ***Increase the attractiveness of working in infant day care by raising the pay.*** There is now a consensus among researchers, care providers and care consumers that the quality of the care arrangement is crucial to the optimal development of each child. This point is not really new. Given the discussion of the effects of group composition on caregiver practices, one wonders how quality will be achieved. Despite the rhetoric about caregiving being a "calling," we must substantially increase the pay for child care providers regardless of setting. In the United States the average full-time, year-round care provider earns approximately $9,900 per year, generally without other benefits. Low pay consistently contributes to significant staff turnover that averages 41 percent of all child caregivers (Whitebook, Howes, Phillips & Pemberton, 1989), thus creating additional discontinuity for young infants and their families during the early attachment period.

❑ ***Consider differential staffing patterns.*** In addition to upgrading salary, we must begin looking at differential staffing approaches. We can no longer afford to place our youngest, most vulnerable, care-dependent infants in the hands of the least qualified and typically least experienced care providers with the mistaken belief that the younger the child, the easier the care. All children deserve a competent and highly qualified caregiver. In circumstances where levels of training and qualifications vary among care providers within a center, however, the most qualified should be considered for the youngest infants, and they should be paid differentially for their competence. In its annual agenda for children, the Children's Defense Fund (1989) identifies a variety of potential funding sources to pay for upgrading salaries for child care providers.

❑ ***Establish federal standards for quality infant care.*** Without clear and defensible federal regulatory standards for both family day care homes and center-based care facilities, quality is compromised. We must push very hard for a lowering of adult-to-infant ratios (preferably 1:3 or lower) and a limit to the practice of increasing numbers within a particular room by hiring more minimally trained staff. Centers and family day care homes should be offered financial and training incentives to undertake accreditation procedures established by the National Association for the Education of Young Children (National Academy of Early Childhood Programs, 1984), which exceed current licensing standards in virtually every state. In essence, we must press for a national consensus and commitment toward children and families.

❑ ***Provide free or inexpensive education and training experiences for infant care providers.*** Finally, continuous educational and training experiences must be made available to all child care providers. Well-developed and systematic forms of training have been shown to reduce the caregiver's reliance on the center director for information and are particularly helpful for newcomers in determining work effectiveness (Powell & Stremmel, 1989). Training must be available to both center-based and family home care personnel.

Creative modes for tapping into cable TV transmission, particularly for family day care homes, may prove productive. Programmatic ideas, basic health and development information and effective communication strategies could be shared with a variety of caregivers in brief, yet powerful episodes. Additionally, these programs could be accompanied by related readings and other course content that yield continuous education credits. Creative efforts such as these are needed to provide helpful and effective educational and training experiences for all infant care providers.

Parents should be empowered as well. Dr. Berry Brazelton has stated that parents who must place their infants and toddlers in all-day care often feel grief and may experience denial and distancing as a result, in order to cope with their feelings. Caregivers must be trained to support these parents and reinforce their parental role as the primary caregivers. One program that has helped parents become family advocates is Parent Action, a political lobbying group devoted to children and family-welfare issues. Such lobbying efforts are crucial if we are to strengthen the fabric of family life for many Americans (Aleshire, 1990).

Conclusion

This chapter explored a number of issues related to the ever-increasing problem of infant child care. It began with the thesis that as the level of care approaches the ratio of 1:1 within the family structure, greater personalization occurs. In contrast, as the complexity of the group composition increases and interacts with the care provider in an out-of-home setting, the greater the probability for less personalization of care with infants. This latter point is a primary concern that has surfaced about the effects of intensive, out-of-home care for very young infants. As parents and care providers reflect on some of the issues raised here, each is reminded to carefully review suggestions and examples for quality care provided by Honig, Castle, Balaban and Sexton (Section I).

In the next and final chapter, Eleanor Szanton explores the realm of policy issues that affect programs for young infants, toddlers and their families.

References

Ad Hoc Day Care Coalition. (1985). *The crisis in infant and toddler child care.* Washington, DC: Author.

Aleshire, P. (1990, January 18). A prescription for children: Pediatrician advises love, political clout. *The Arizona Republic,* p. 2.

Belsky, J. (1988). The "effects" of infant day care reconsidered. *Early Childhood Research Quarterly, 3,* 235-272.

Belsky, J., & Steinberg, L.D. (1978). The effects of day care: A critical review. *Child Development, 49,* 929-949.

Children's Defense Fund. (1989). *A vision for America's future. An agenda for the 1990s: A children's defense budget.* Washington, DC: Author.

Clarke-Stewart, K.A. (1988). Evolving issues in early childhood education: A personal perspective. *Early Childhood Research Quarterly, 3,* 139-149.

Eheart, B.K., & Leavitt, R.L. (1989). Family day care: Discrepancies between intended and observed caregiving practices. *Early Childhood Research Quarterly, 4,* 145-162.

Fox, N., & Fein, G.G. (1988). Infant day care: A special issue. *Early Childhood Research Quarterly, 3,* 227-234.

Hofferth, S.L. (1989). What is the demand for and supply of child care in the United States? *Young Children, 44*(5), 28-33.

Hofferth, S.L., & Phillips, D.A. (1987) Child care in the United States, 1970 to 1995. *Journal of Marriage and the Family, 49,* 559-571.

National Academy of Early Childhood Programs. (1984). *Accreditation criteria and procedures of the National Academy of Early Childhood Programs.* Washington, DC: National Association for the Education of Young Children.

Powell, D.R. (1989). *Families and early childhood programs.* Washington, DC: National Association for the Education of Young Children.

Powell, D.R., & Stremmel, A.J. (1989). The relation of early childhood training and experience to the professional development of child care workers. *Early Childhood Research Quarterly, 4,* 339-355.

Sroufe, L.A. (1988). A developmental perspective on day care. *Early Childhood Research Quarterly 3,* 283-291.

Wallis, C. (1987, June 22). Is day care bad for babies? *Time,* p. 63.

Whitebook, M., Howes, C., Phillips, D., & Pemberton, C. (1989). Research report: Who cares? Child care teachers and the quality of care in America. *Young Children, 45*(1), 41-45.

Wingert, P., & Kantrowitz, B. (1990, Winter/Spring). The day care generation. *Newsweek Special Edition,* pp. 86-92.

Zill, N. (1988). *Basic facts about the use of child care and preschool services by families in the U.S.* Washington, DC: Child Trends.

Zimiles, H. (1989). *The adoration of "hard data": A case study of data fetishism in the evaluation of infant day care.* Unpublished manuscript, Arizona State University, Tempe.

Zinmeister, K. (1988, October). Hard truths about day care. *Reader's Digest,* pp. 88-93.

Chapter 7

Policy Issues Affecting Infants, Toddlers and Their Families

Eleanor Stokes Szanton
National Center for Clinical Infant Programs

This publication has laid out in some detail our current understanding of how infants and toddlers develop or fail to develop. It has reviewed ways in which programs need to be improved and adapted in order to better address the health and child care needs of the nation's youngest children and their families.

The purpose of this chapter is to review the current status of our youngest children and their families, highlight current policy issues and propose directions for future policy initatives.

Facts About the Status of the Nation's Youngest Children

By a number of indicators, infants and toddlers in the United States today are at greater risk than at any time in recent memory. For example:

❑ As mentioned by Feeg in the previous chapter, an ever-increasing proportion of the impoverished are young children. Almost one quarter of all children under 5 years of age were living in poverty in 1985—23 percent of all children under 5 years of age, as compared to 14 percent of individuals of all ages (U.S. Bureau of the Census, 1987). More specifically, according to 1987 data, among children under age 3, one in four is poor. In fact, of eight industrial democracies, the U.S. has the highest poverty rate (Children's Defense Fund, 1989).

❑ The number of children under age 6 living with their mother alone had increased from 15.4 percent in 1980 to 20 percent in 1985. The number of black children under 6 living with a mother only had increased from 39.5 percent in 1980 to 54.1 percent in 1985 (U.S. Bureau of the Census, 1987). It has been projected that by the year 2000, children who live in single-parent families will increase by 2.8 million (Children's Defense Fund, 1989).

❑ Though the number of children born to teenage women has been decreasing, the number born to unmarried teenagers has rapidly increased. By 1985 more than half of all births to teenagers were to unmarried teenagers (National Center for Health Statistics, 1987). These figures have implications not only for children and families, but for the nation's economic future.

❑ The incidence of children exposed to drugs in utero is increasing sharply. A recent survey of a representative sample of U.S. hospitals found that, on average, 11 percent of children born had been so exposed (Chasnoff et al., 1989). Moreover, the readers are reminded of the potentially understated figures mentioned earlier of narcotic-addicted infants (Feeg, chapter 5).

❑ Though the infant mortality rate has declined steadily over the past quarter century, it is still higher than that in 17 other industrialized countries. The black infant mortality rate is now almost twice as high as white, and the disparity is increasing (National Center for Health Statistics, 1986, December, p. 230).

❑ Much of the decline in infant mortality can be attributed to our ability to save more children of much lower birthweight and much greater prematurity than before, rather than improvements in prenatal or postneonatal care. In 1984, 6.7 percent of all women giving birth produced low birthweight babies (weighing less than 2500 grams or 5 pounds, 8 ounces). Among black women, 12.4 percent gave birth to low birthweight infants, as did 12.8 percent of all women under age 15 (National Center for Health Statistics, 1987a, June, p. 11). Almost one quarter of all babies born between 1979 and 1985 were to women who had had no prenatal care in the first three months of their pregnancy (National Center for Health Statistics, 1987b, July, p. 9).

❑ The rate at which the nation's youngest children die of accidents has decreased dramatically over the past decade, thanks largely to increased use of seatbelts and well-constructed car seats (National Center for Health Statistics, 1985). Homicide is now the largest single cause of violent death of children under 1 year of age in the U.S. (Baker & Waller, 1989).

❑ The number of young children reported to be suffering abuse and neglect continues to increase significantly, having almost tripled since the mid-1970s (American Association for Protecting Children, 1987, pp. 3-4).

❑ An increasing number of children under 5 years of age have AIDS. Though the number remains relatively small (under 500 as of July 1988), the figure doubled from 1987 to 1988 (Centers for Disease Control, 1988). As mentioned by Feeg, since the largest cause of new cases of AIDS among infants is that their mothers, many of whom are drug addicts, have the disease as well, these children are frequently not in a situation where their families are able to care for them. According to the American Academy of Pediatrics, by 1991 children with AIDS will account for 10 percent of all hospitalized children (Williams, 1989).

❑ More than half of all U.S. children under age 3 now have mothers in the labor force (National Center for Clinical Infant Programs, 1988). Though there is every reason to believe that these children can thrive in environments of high quality, as suggested by Kelley and Surbeck in the previous chapter, many are in child care arrangements that are unsafe, unhealthful, unregulated and not based on sound principles of early child development. The National Day Care Staffing Study recently completed (Whitebook, Howes, Phillips & Pemberton, 1989) confirms that in the last eight years these problems in child care have not been resolved.

Almost as distressing as the facts we know are those which we can only guess. For example, we have no systematic way of finding children who are potentially at risk of abuse or neglect, the number who are developing significant mental health problems and the number beginning to show developmental delays or potentially handicapping conditions. All too often we do not know who these children are until after their families have been reported for abuse or they are labeled as needing special education in 1st grade.

In sum, in one domain after another a significant number of babies and toddlers are at risk. Yet in some particularly important areas, that risk status is not identified until after the situation has become critical.

© 1990 Hildegard Adler

Cumulative Risk: What the Research Tells Us

A further alarming fact must be added. Recent research has demonstrated that for young children risk rises in geometric rather than linear proportions. For a child whose development is at risk for four different reasons (such as low birthweight, slight neurological impairment, very young mother, substandard child care), the chances of poor developmental outcome rise astronomically (Sameroff, Seifer, Barocas, Zax & Greenspan, 1987). The result seems to be, sadly, a two-tiered society emerging from very earliest childhood.

Change on the Horizon

Although the need for preventive and coordinated programs to serve infants, toddlers and families has been discussed in the professional literature for more than 13 years (Watson, 1977), a consensus seems to be developing across the political spectrum that more attention must be paid to the needs of America's youngest children. The nation's governors, business leaders, as well as officials at other levels of government, have seen the importance of action in this area. Yet they are moving in a direction that may lead to further categorical labeling of children and families rather than the broad provision of services, which all children and families deserve.

Service Delivery Difficulties

Over the years individual professional disciplines have emerged to address some *portion* of human need. As such, they remain (and should remain) the repository of highly specialized accumulated wisdom. Yet the agencies and institutions that organize and deliver this professional expertise have found it difficult to give priority to the needs and convenience of *consumers* over and above those of providers. Parents of children with special needs must make their way through the thickets of multiple institutions, each providing only part of a needed cluster of services. Very often severely stressed families do not have the stamina or confidence to pursue the services potentially available. This is especially so when only a "label" will instigate a service.

This categorical approach is a problem for families that "slip through the cracks" between services or who end up with redundant services. Categorizing perpetuates the negative, labeling conceptualization of what infants and their families need. Very few parents would voluntarily put their children in a program for which they must be labeled "at risk of mental retardation" and the family designated as "a contributing factor" to that risk. Yet this is exactly the kind of choice being presented to already stressed families! Sometimes euphemisms are invented that designate the children "high priority" or "having special needs." But when those who provide services write their proposals, when they go to their legislators or insurance companies or to the federal government for compensation for these services, they must use this negative, disaster-prevention model.

Federal Programs: The Deficit View

One can name easily 20 major federal (or federally monitored) programs affecting infants, preschoolers and school-age children. By far the largest number are intended to *prevent or diminish a deficit*. The various deficits or disasters that programs such as Food Stamps, Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI) are designed to prevent include death, destitution, malnutrition and/or starvation, illness, mental illness, developmental delay, handicapping conditions, child abuse and excessive burdens on society.

A Positive Model: What It Could Mean

I want to propose a more positive model. Such a model makes a commitment to all families and their children, providing options for personalizing health and child care choices. It is based on the principle that *all* infants have certain rights to life, happiness and a strong start and that *all* families need a range of aids and supports in order to be able to assure them a basic existence in today's complex society. Some need help along a broader segment of the spectrum than others; some are less able than others to find and pay for it themselves. It should be the role of those who organize and pay for systems of services to develop models that reflect this reality. For example, in chapter 4 of this book, Sexton suggests an integrated family-focused model of service delivery within more typical, integrated settings for young infants and toddlers who fall under the rubric of P.L. 99-457.

Present Federal Programs: The Deficit or the Positive Model?

As one looks at federal programs designed to help infants and toddlers as well as their older brothers and sisters, one can begin to see some important shifts from the "deficit" to the "right to life, happiness and a strong beginning" frame of reference. Many of these programs provide important services to which all should have access, and they can be further broken down into three categories:

1) ***Services Offered to All, Regardless of Ability To Pay.*** Only public school for children ages 6-18 currently fits this category.

2) ***Services Offered to All Who Cannot Afford To Pay.*** Various other programs are beginning to move into this category from the deficit category (or from small experimental programs). Prominent among these are Medicaid and related childhood immunization and maternal and child health programs. The recent dramatic spread in Medicaid eligibility to cover the working poor enables it and the maternal and child health programs to offer more positive aid.

Another cluster of programs that have moved to the positive side of the ledger—some from the deficit umbrella, others from the small experimental category—is the Head Start cluster (Head Start, which began as "compensatory," Even Start and Smart Start). Together, this set of programs is beginning to transmit the notion that all children deserve preschool education and that those who cannot afford to pay for it privately should have it at state expense. Unfortunately, there are still many eligible children not covered by these programs; but the programs are spreading quickly.

Adequate child care for those who cannot afford it falls into both categories. The Child Care Tax Credit, available to all but the most highly compensated taxpayers, is not a compensatory program. Yet it falls far short of providing adequate child care support for lower income families. Perhaps this will change in the early 1990s. Title XX has become a much smaller source of federal funds for day care. It lost so much ground in the 1980s that it has virtually moved to the category of "interesting experimental model." With the passage of the Family Support Act of 1989 (the welfare reform bill), there is some evidence that support for child care guaranteed to its participants may be squeezed under the "deficit" rather than the "important service" rubric, since the bill does not pretend to provide developmental child care. The success of this will depend on how states respond to this initiative.

3) *Interesting Models of a Positive Sort.* Three other actual or potential programs with a positive model but only sporadic funding deserve mention. One dates back to the 1960s—the Parent-Child Centers of Head Start. A second has just been enacted—the Comprehensive Child Development Center Act, to be administered by Head Start. The third, the Child Care and Development Block Grant, was also just enacted by Congress and approved by President Bush. It is a comprehensive five-year plan that would help pay child care costs of working parents and impose a few regulations on the child care industry. This legislation will involve the federal government in partnership with state, local and private child care efforts.

All three of the above programs have been designed to provide a useful, added boost to families. Unfortunately, all three have been or are likely to be funded accompanied by rhetoric about preventing "deficits."

The Need for Policy Action Is Now

It is no accident that, aside from programs to curb infant mortality and the incidence of low birthweight babies, funding becomes more sporadic and categorical as the target population diminishes in age. It is easy to forget these children. Yet ironically, unless immediate and coordinated policies are enacted, this is precisely the group that appears most at risk to become a generation lost to ruptured family lives, poor physical and emotional health, mediocre or incomplete education, drugs and despair. What policy issues specific to infants, toddlers and families need addressing?

- ❑ More accessible primary preventive health care, including timely immunizations, for *all* pregnant women, infants and toddlers through fully implemented Medicaid and private insurance coverage
- ❑ More systematic screening for developmental problems in the earliest years, through EPSDT and child identification programs administered under P.L. 99-457
- ❑ More universally accessible nutrition programs for eligible pregnant mothers, infants and toddlers, through increases in the Department of Agriculture's WIC and Child Care Food Programs
- ❑ Increasingly effective drug, alcohol and smoking prevention, public education and rehabilitation programs that allow treatment of the entire family unit
- ❑ A reversal of the present erosion of economic standards of young, impoverished parents through adequate levels of AFDC reimbursement, available housing and the use of tax deductions and credits
- ❑ An adequate number of family resource programs providing new parents with parent education, drop-in arrangements and other family services
- ❑ The institution of at least six months of paid parental leave for new parents, with job protection and benefits maintained
- ❑ An adequate supply of high-quality, affordable child care—both family day care and center-based care, including resource and referral centers
- ❑ Improved, expanded programs for infants and toddlers who have special health care needs, disabilities or who are at high risk of developing these
- ❑ Improved expanded social support services for highly stressed families

And most important, firm linkages between all these programs (National Center for Clinical Infant Programs, 1986, pp. 8-11).

Conclusion

The challenge for the 1990s for those who fund and provide services for very young children and their families, then, is twofold. The first is to bring them from a "deficit" to an "important service" mode of thinking. The second challenge is to broaden what each service offers. When WIC nutrition programs can be delivered at the Medicaid checkup, when the EPSDT or screening for P.L. 99-457 can occur in the course of normal day care or preschool, when each family has access to a wise resource that can advise on parenting and provide solid linkages to more specialized and personalized services—then we will have truly met the challenge to give the next generation the beginning it deserves.

References

American Association for Protecting Children, Inc. (1987). *Highlights of official child neglect and abuse reporting, 1985* (pp. 3-4, Figures 1 & 2). Denver, CO: The American Humane Association.

Baker, S., & Waller, A. (1989). *Childhood injury state by state mortality facts.* Baltimore, MD: Injury Prevention Center, Johns Hopkins School of Hygiene and Public Health.

Centers for Disease Control. (1988, July). *AIDS weekly surveillance report.* Atlanta, GA: United States AIDS Program, Center for Infectious Diseases.

Chasnoff, I.J., Griffith, D.R., MacGregor, S.N., et al. (1989). Temporal patterns of cocaine use in pregnancy: Perinatal outcome. *Journal of the American Medical Association, 261,* 1741-1744.

Children's Defense Fund. (1989). *A vision for America's future. An agenda for the 1990s: A children's defense budget.* Washington, DC: Author.

National Center for Clinical Infant Programs. (1986). *Infants can't wait.* Washington, DC: Author.

National Center for Clinical Infant Programs. (1988). *Infants, families and child care: Toward a research agenda.* Washington, DC: Author.

National Center for Health Statistics. (1985). *Vital statistics of United States, Vol. II, Mortality, part A, 1950-84.* (DHHS Publication No. PHS 85-1101). Washington, DC: U.S. Government Printing Office.

National Center for Health Statistics. (1986, December). *Health United States 1986* (DHHS Publication No. PHS 87-1232). Washington, DC: U.S. Government Printing Office.

National Center for Health Statistics. (1987a, June). *Monthly vital statistics report, 36*(3), *Supp.* (DHHS Publication No. PHS 87-1120). Hyattsville, MD: Public Health Service.

National Center for Health Statistics. (1987b, July). *Advance report of final natality statistics, 1985. Monthly vital statistics report, 36*(3) *Supp.* (DHHS Publication No. PHS 87-1120). Hyattsville, MD: Public Health Service.

Sameroff, A.J., Seifer, R., Barocas, R., Zax, M., & Greenspan, S. (1987). Intelligence quotient scores of four-year-old children: Socioenvironmental risk factors. *Pediatrics, 79*(3), 343-350.

U.S. Bureau of the Census. (1987). *Current population reports, series P-60, No. 158, Poverty in the United States: 1985.* Washington, DC: U.S. Government Printing Office.

Watson, J. (1977). What a state can do for infants. In M. Cohen (Ed.), *Developing programs for infants and toddlers* (p. 11). Wheaton, MD: Association for Childhood Education International.

Whitebook, M., Howes, C., Phillips, D., & Pemberton, C. (1989). Research report: Who cares? Child care teachers and the quality of care in America. *Young Children, 45*(1), 41-45.

Williams, A. (1989). Nursing management of the child with AIDS. *Pediatric Nursing, 15*(3), 259-261.

Postscript

Elaine Surbeck
Arizona State University

The focus on personalization of care and services with families of infants and toddlers emerged during continued discussions between the author and the mother of an infant and a preschool-age child. As Barbara struggled with her own guilt about leaving 6-week-old Marissa and the difficulties in finding adequate child care for both children, we explored many frustrations, questions and issues together. We developed the shared belief that high quality infant caregiving is more than responding to normative or even individual characteristics of a child. It is a unique and personal response learned through countless hours of living with a child. Moreover, it is different for each child.

Perhaps the choices were especially painful for Barbara because her career is in child care; the knowledge she has about child development created even sharper doubts about available options. Barbara and Marissa were relatively lucky. At nearly 2 years of age, Marissa has known only two other primary caregivers who used relatively few back-up babysitters. She has enjoyed the type of experiences with nurturant adults that are described in the first chapters of this book.

For a nation as well-developed as the United States, however, far too many babies do not experience the kind of loving, consistent and rich reciprocal, personal interactions that foster healthy social, physical and emotional development within a family. As editors of this book, we hope you are shocked and shamed by the fragmented policies at national, state and local levels. The implications of the information presented in Section II should appall you. As Szanton suggests, we are in danger of creating a two-tiered system in the United States. We are in fact, however, interdependent upon one another for the long-term well-being of society. If we do not assist all families in providing a healthy and positive beginning for our youngest citizens, the whole fabric of our democratic system may unravel.

It is interesting to note that in 1976 and 1977, ACEI published similar books on infants, toddlers and programs. Although information about the development of children has increased greatly since that time, it is striking to note that the concerns about the provision of quality care and programs are virtually the same today as then. Only the statistics have changed, indicating that many more infants and toddlers are at higher risk levels for health and adequate nurturance. In nearly 15 years, little progress has occurred in the policy arena. It is not enough to proclaim again that the United States is facing a crisis in social policy directed toward families and then rest on the laurels of rhetoric. The voices of professionals in the fields of early education and child development have been subdued far too long.

Zimiles (cited in "Infant Day Care" chapter) suggests that the silence of professionals has been caused by a) the pleasure they receive in the increased emphasis placed on early education and b) the belief that research data alone (rather than professional opinion) provide the basis for policy development. Longitudinal data are extremely important, but equally important are knowledgeable voices of clini-

E. Anne Eddowes

cians and practitioners who live and work with children and their families and who know what is needed to personalize care and services with families.

If changes are to occur in this crisis, alternatives and solutions will begin only when we act. Each of us has the responsibility to demand and help build national, state and local policy that will support and empower families.

At the federal level, we must continue to articulate to our representatives in Congress the need for coordinated services that improve the status of families. Resources effective for this dialogue include:

- ❑ This book
- ❑ *Who Will Mind the Babies?* National Center for Clinical Infant Programs, 2000 14th St. North, Suite 380, Arlington, VA 22201; (703) 528-4300
- ❑ *A Vision for America's Future: An Agenda for the 1990s.* Children's Defense Fund; available from NAEYC, 1834 Connecticut Ave., NW, Washington, DC 20009; (800) 424-2460

In the Children's Defense Fund publication, the voting record of each state's senator and representative is shared. Look at those votes to determine whom to contact systematically. Campaign for those elected officials who are responsive to children and families.

Although banding together with local advocacy groups supplies support and resolve, individual letters to your elected officials carry additional weight. The proper form for addressing senators is: The Honorable _____, U.S. Senate, Washington, DC 20501. For congressional representatives: The Honorable _____, U.S. House of Representatives, Washington, DC 20515. Representatives or senators may be reached by calling the U.S. Capitol Switchboard: (202) 224-3121.

At the state and local levels, each of us must make a similar commitment to informing state lawmakers of the issues associated with the personalization of care for children and families. Unfortunately, many of the woefully inadequate existing child care standards are currently subject to legislative relaxation in many states as a way to increase the availability and supply of child care. We cannot allow this to happen.

In the 1990-91 federal budget negotiations, the 101st Congress, with concurrence from President Bush, allocated approximately $22 billion to be made available over five years for child care. The money is to provide before- and after-school programs, assist the working poor in obtaining child care, and expand and improve health, safety and personnel training standards. Roughly $12 billion of the total is earmarked for the Earned Income Tax Credit. Thus, families whose income is below $20,000 will receive an additional $500 tax credit. Interestingly, this credit is not obligated for child care expenses and parents who care for their own children will be eligible.

While this is a beginning, we must continue to press for the creation of *quality, personalized* care options responsive to all families with young children. As Burton White has said, if we as professionals do not take a stand for babies and their families, then who will?